I: State Information

State Information

Plan Year
Start Year: 2012
End Year: 2013

State SAPT DUNS Number
Number
Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant
Agency Name
Idaho Department of Health and Welfare
Organizational Unit
Division of Behavioral Health
Mailing Address
450 West State Street
City
Boise
Zip Code
83720-0036

II. Contact Person for the SAPT Grantee of the Block Grant
First Name
Richard
Last Name
Armstrong
Agency Name
Idaho Department of Health and Welfare, Division of Behavioral Health
Mailing Address
450 West State Street
City
Boise
Zip Code
83720-0036
Telephone
208-334-5500
Fax
208-334-6558
Email Address
OsbornJ@dhw.idaho.gov

State CMHS DUNS Number
Number
825201486
Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant
Agency Name
II. Contact Person for the CMHS Grantee of the Block Grant

First Name
Richard

Last Name
Armstrong

Agency Name
Idaho Department of Health and Welfare, Division of Behavioral Health

Mailing Address
450 West State Street

City
Boise

Zip Code
83720

Telephone
208-334-5500

Fax
208-334-6558

Email Address
OsbornJ@dhw.idaho.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
7/1/2010

To
6/30/2011

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date
10/4/2012 3:50:16 PM

V. Contact Person Responsible for Application Submission

First Name
Cynthia

Last Name
Clapper

Telephone
208-334-5527

Fax
208-332-5998

Email Address
clapperc@dhw.idaho.gov

Footnotes:
The Block Grant was co-written by both Cynthia Clapper and Heidi Lasser
I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name: Richard M. Armstrong
Title: Director
Organization: Idaho Department of Health and Welfare

Signature: ___________________________ Date: ___________________
I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (?), (d), (?), and (f).

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

<table>
<thead>
<tr>
<th>Name</th>
<th>Richard M. Armstrong</th>
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<tbody>
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<td>Title</td>
<td>Director</td>
</tr>
<tr>
<td>Organization</td>
<td>Idaho Department of Health and Welfare</td>
</tr>
</tbody>
</table>

Signature: ___________________________ Date: ________________

Footnotes:
I: State Information

Chief Executive Officer’s Funding Agreements/Certifications (Form 3) [SAPT]

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. FORMULA GRANTS TO STATES, SECTION 1921

II. Certain Allocations (Prevention Programs utilizing IOM populations; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS (IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

XI. Restrictions on Expenditure of Grant, Section 1931

XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Continuation of Certain Programs, Section 1953
I hereby certify that Idaho will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

<table>
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<th>Richard M. Armstrong</th>
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<td>Idaho Department of Health and Welfare</td>
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</table>

Signature: __________________________  Date: ______________________

Footnotes:
I: State Information

Chief Executive Officer’s Funding Agreements/Certifications (Form 3) [CMHS]

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Idaho agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1) & (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)

(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.

(C) 24-hour-a-day emergency care services.

(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.
(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section.

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.
Notice: Should the President’s FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

<table>
<thead>
<tr>
<th>Name</th>
<th>Richard M. Armstrong</th>
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Signature: ____________________________ Date: ____________________
I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:
II: Planning Steps

**Step 1: Assess the strengths and needs of the service system to address the specific populations**

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:
Assessment of the strengths and needs of the service system to address the specific populations

Provide an overview of the State’s behavioral health prevention, early identification, treatment and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels不同iating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Behavioral Health Prevention, Early Identification, Treatment and Recovery Support Systems

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff’s Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision; “Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery. Goals included the following; 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

The BHTWG’s efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho’s Behavioral Health System (October 28, 2010). This report’s recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council to the State Behavioral Health Council; establishing the Behavioral Health Interagency Cooperative to oversee transformation efforts; and adopting the BHTWG’s proposed Array of Core Services “…as the ‘floor’ of services they seek to make available in each region.” The report recommends, “…that this array be maintained as the goal for regional planning and capacity building; and that is also be used as a measure by which to indicate progress toward a truly transformed behavioral health system…” The following are the core regional services recommended by the BHTWG:

1. Psychiatric Emergency and Crisis Intervention Services
2. Assessments and Evaluations
3. Designated Examinations and Dispositions
4. Inpatient Psychiatric Hospitalization
5. Medication Management
6. Case Management Services
7. ACT, Intensive Case Management, Wraparound Services
8. Psychotherapy
9. Intensive Outpatient Services
10. Drug Screening
11. Alcohol and Drug Residential Treatment
12. 24-Hour Out-of-Home Treatment Interventions for Children & Adolescents
13. Illness Self-Management
14. Peer Support Services
15. Prevention Services
16. Early Intervention Services for Children & Adolescents
17. Supported Employment
18. Supported Housing
19. Transportation
20. Day Treatment, Partial Care, and Partial Hospitalization

The BHTWG recognized that the development of the entire array of core services in each region will take time. It is recommended that the core services be divided into two categories: 1) Initial Core Services that will be required from the start to be available to all consumers; and 2) Supplemental Core Services that will be evolved by the Regional Behavioral Health Community Development Boards. The following are lists of the Initial and Supplemental Core Services:

**Initial Core Services**
1. Psychiatric Emergency and Crisis Intervention Services
2. Assessments and Evaluations
3. Designated Examinations and Dispositions
4. Inpatient Psychiatric Hospitalization
5. Medication Management
6. Case Management Services
7. ACT, Intensive Case Management, Wraparound Services
8. Psychotherapy
9. Intensive Outpatient Services
10. Drug Screening
11. Alcohol and Drug Residential Treatment
12. 24-Hour Out-of-Home Treatment Interventions for Children & Adolescents

**Supplemental Core Services**
1. Illness Self-Management
2. Peer Support Services
3. Prevention Services
4. Early Intervention Services for Children & Adolescents
5. Supported Employment
6. Supported Housing
7. Transportation
8. Day Treatment, Partial Care, and Partial Hospitalization

Services will be provided in accordance with statewide standards which will include monitoring for quality, consistency, and effectiveness. The State Behavioral Health Authority will be responsible to develop and monitor the statewide standards of care for the initial and supplemental care services.

Each Behavioral Health Regional Development Board will be expected to develop a Regional Transformation Implementation Plan that describes the availability, quality, consistency and effectiveness of Initial and Supplemental Core Services and plans for addressing gaps in any of the service areas. As the system evolves, criteria based on these factors will be used to assess the “readiness” of a region to assume greater responsibility for the management of core services offered in the region.

Governor Otter signed Executive Order 2011-01 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. One charge to the IBHIC is to “d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho’s Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho’s budget, current needs of the agencies, and recommendations of the Idaho Health Care Council.”
As of 5/13/11, the IBHIC “to do” list was broken into four phases. All phases began with finalizing funding and ended with providing an annual status report to the Governor. **Phase 1** also included planning regional behavioral health development boards and state behavioral health planning council (e.g., identifying proposed membership, proposing an implementation timetable, soliciting and reviewing input and drafting legislation to implement regional behavioral health development boards to submit to the 2012 legislature); establishing core services for all regions and drafting 2012 legislation proposals; developing a transformation work plan, communications protocol and proposed transformation activity funding for SFY 2013; and reviewing SUDS treatment services and data report elements. Additional **Phase 2** activities included finalizing core services standards for the transformed behavioral health system; initiating regional transformation efforts and coordinating transformation activities with health care reform activities. **Phase 3** activities included developing a ‘Transformation Implementation Plan’ that applies to all Cooperative entities; developing regional Transformation Implementation Plans; monitoring and evaluating phase-in and recommending adjustments to State and Regional Transformation Plans; and coordinating transformation activities with health care reform activities. **Phase 4** included continuing phase-in of transformation, drafting legislation to implement the next phase; and coordinating transformation activities with health care reform activities.

**Public Behavioral Health System Organization at the State, Intermediate and Local Levels**


The Department of Health and Welfare is designated by statute (Idaho Code Section 39 Chapter 3) as the State Mental Health Authority (SMHA) and as the Single State Authority (SSA) for Substance Use Disorders (SUD) prevention and treatment. Most of these responsibilities are carried out by the Department’s Division of Behavioral Health. The Division of Behavioral Health’s Central Office includes Adult Mental Health (AMH), Children’s Mental Health (CMH), Substance Use Disorders (SUD) and a Data Unit. The Central Office component of the Division of Behavioral Health provides system coordination and leadership, policy and standards development, rule promulgation and interpretation, technical assistance, training, consultation, funding application and regulation, and quality assurance monitoring.

Adult and Children’s Mental Health services and SUD services are provided in each of the seven (7) IDHW geographically defined Regions. The SMHA services are offered through state operated community mental health centers (CMHC’s) in each region. Treatment services include crisis response, assessment and a range of mental health services available to eligible adults with serious mental illness, children with serious emotional disorders and their families. Idaho’s two (2) state psychiatric hospitals, State Hospital North and State Hospital South, are also under the jurisdiction of the DBH Administrator. State Hospital North serves adults only while State Hospital South serves both adults and adolescents.

The SSA oversees treatment to adolescents, adults, pregnant women and women with dependent children who are below 200% of the federal poverty rate and who are diagnosed as substance dependent with at least an outpatient need according to the ASAM (PPC 2R, Level 1). Treatment referral sources include judges and Drug Courts. Treatment services include assessment using the Global Appraisal of Individual Needs (GAIN), individual and group counseling, education in social settings, residential and detoxification services and case management. The Division contracts with the Management Services Contractor, Business Psychology Associates (BPA), to manage the treatment service delivery through a network of Department approved treatment providers. BPA also provides care management utilization review. Care Management responsibilities include use of a statewide 1-800 number for eligibility screenings, to make an initial ASAM PPC-2R level of care determination and to prior authorize units of
service. The Division’s SUD program also oversees substance abuse prevention at three levels for those at no or low risk of substance abuse. At the State level, the Division supports an alcohol/drug clearinghouse and provides education funding to prevention professionals. At the community level, the Division provides technical assistance and support to the Community Coalitions of Idaho (i.e., a coalition of community anti alcohol/drug coalitions). At the individual level, the Division funds community-based providers to deliver evidence-based education and other prevention strategies designed to reduce the risk factors of universal, selective and indicated populations. The SUD prevention services also include prevention intervention for youth who are either at high risk for substance abuse or who may have experimented with tobacco or alcohol but do not meet the criteria for the .5 level of care.

The Division contracts with Benchmark Research and Safety (BRS), the Prevention Technical Assistance and Support Contractor (PTASC), to manage the community-based prevention provider network. Benchmark’s responsibilities include conducting annual state and regional needs assessments used to identify at-risk populations and underserved areas, supporting the preventionidaho.net website (i.e., the prevention data system that collects provider data), collecting staff and program information, hosting online prevention course and generating data used for local and federal reporting requirements (e.g., block grant, prevention data for the National Outcome Measures (NOMS), etc.).

The Idaho Division of Behavioral Health focuses on mental health (adults and children) and substance use disorder (adults and children) policymaking, service planning and implementation for Idaho citizens diagnosed with a serious mental illness, a serious emotional disorder or a substance use disorder. Several organizational changes were implemented at the Division of Behavioral Health in SFY 2011. Effective July 1, 2010, the seven (7) Regions were organized into three service areas or “hubs.” The management team for the Division of Behavioral Health (DBH) for is composed of the hub heads and the unit leads. The DBH Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). Program Managers in Region 3, Region 4, and Region 5 report to the southwestern hub Administrator. The DBH Administrator at Central Office has oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs.

The U.S. Census Bureau (2010) indicates that that Idaho’s population is 1,567,582, with 9 rural counties (i.e., no population center of 20,000 or more and six or more persons per square mile), 17 frontier counties (i.e., less than six per square mile) and 18 urban counties. Idaho ranks 13th in area size of the fifty states, with 82,747 square miles and diverse areas that include mountains, deserts, farmland and canyons. Local SMHA service delivery is based on seven geographical Department of Health and Welfare service areas. Publicly funded adult mental health (AMH) and Children’s Mental Health (CMH) services are provided through Regional DBH center sites, with one Regional Program Manager responsible to oversee service delivery and quality for both programs. Psychiatric services may be supplemented through telehealth video conferencing to rural and frontier locations. The high definition video conference system is also used for statewide meetings, including meetings of the State Planning Council on Mental Health. In SFY 2011, there was a cost savings for all video conference users (not just the Division of Behavioral Health) of $312,366.00.

Priority local services for AMH and CMH are directed to crises and court-ordered clients, with voluntary clients served as there is room in the system. Efforts are made to refer Medicaid eligible clients to Medicaid eligible private provider resources. Idaho subscribes to an integrated service delivery system. Service components include mental health, social services, education, health, vocational services and corrections. Recognizing that services are provided by multiple public and private agencies, the Division continues to seek cooperative agreements with other departments and providers.
Highlights of the AMH service array include medication management, Assertive Community Treatment (ACT), co-occurring integrated disorders treatment, crisis response, collaboration with vocational rehabilitation and strong collaboration with mental health courts. Recovery and resilience are modeled through inclusion of Certified Peer Specialists on regional ACT teams and use of Certified Peer Specialists as outreach providers through the Projects for Assistance in Transition from Homelessness (PATH) program. The AMH programs and the courts coordinate treatment plans and service delivery with mental health court referred clients, with most eligible clients provided individual and group services by regional ACT teams. During SFY 2009 and SFY 2010, Mental Health Court Utilization operated at approximately 90% of capacity.

The AMH program provides services to adults diagnosed with a serious mental illness who are homeless or at risk of becoming homeless. The SFY 2011 Projects for Assistance in Transition from Homelessness (PATH) grant funds were directed to a small contract with a Region 1 local provider; to a small amount for each regional CMHC to help with housing costs (i.e., one time rental assistance or security deposits); with the majority of funds allocated to a contract with the Office of Consumer and Family Affairs (OCAFA). The OCAFA contract allows for two PATH Certified Peer Specialists, each working 19 hours per week, to be assigned to each of seven regional DBH service sites. The PATH Certified Peer Specialists strive to conduct up to 75% of their time in face to face outreach to those in their region who have a mental health diagnosis and who are literally homeless. This program was implemented in April 2011. In addition to receiving training in evidence based practices related to Supported Housing, Supported Employment and SSI/SSDI Outreach and Recovery (SOAR), PATH Peer Specialists were also trained in Mental Health First Aid in June 2011 through a Center for Social Innovations technical assistance opportunity. Additional resources to the homeless include the Charitable Assistance to Community’s Homeless (CATCH) program. This program mobilizes community resources for those who are homeless in Regions 3 and 4. The Idaho Housing and Finance Association (IHFA) manages Shelter Plus Care vouchers in all but Regions 3 and 4, where housing services are handled through the Boise City/Ada County Housing Association (BCACHA). The process for accessing Shelter Plus Care was standardized in SFY 2009, leading to an increased level of regional involvement with this program. Because the growth exceeded the supply, IHFA stopped accepting referrals to Shelter Plus Care in April, 2011 for an indefinite period of time.

Special projects serving adults diagnosed with serious mental illness and/or substance use disorder diagnoses include the Wood Project and the Allumbaugh House detoxification center. Both projects were initially supported through legislatively allocated funds to identify unmet local needs and develop a plan to address those needs. The Bonneville County’s Substance Abuse/Mental Health Treatment Program (i.e., the Wood Project) provides mental health and substance abuse assessments, drug testing and treatment to male and female offenders who are likely to be sentenced to correctional facilities. This program SFY 2008 legislative allocation of $1,240,000 was reduced to $1,083,400 in SFY 2011. The Allumbaugh House opened May 2010 in Boise and is operated through a contract with Terry Reilly Health services. This facility offers treatment services that include crisis mental health, medically monitored chemical detoxification and sobering stations. Sobering station referrals are accepted from health care providers and local law enforcement. Legislative operating allocations for this facility were reduced from $900,000 to $787,400 in SFY 2011.

The CMH system’s comprehensive system of care includes assessment, case management, family support (e.g., family preservation, counseling, transportation, parent skills training and education, flexible funding and peer support) and family respite. The Division contracts with a private provider to maintain a statewide family to family support network, to provide a statewide respite information and referral center, and to recruit and train respite care providers. The CMH program also provides therapeutic foster care, crisis response, school mental health services, outpatient, residential and hospitalization. State Hospital
South’s 16-bed Adolescent Unit provides inpatient stabilization and treatment, with average lengths of stay of 45 to 90 days. Longer term treatment may be provided by foster parents and residential facilities. Some unique aspects of the CMH program that are not available in the community or through existing benefit packages include provision of the evidence based Parenting with Love and Limits (PLL) intensive outpatient program, wraparound and clinical case management.

The CMH Division of Behavioral Health program works closely with the Department of Health and Welfare’s Child Welfare Program and with the Department of Education. A memorandum between CMH and Child Welfare describes how services will be coordinated for shared clients. The Department’s Service Integration program facilitates family efforts to navigate the range of Department programs and services. The Service Integration program works with Idaho’s Health Information and Referral Center, or the 211-Idaho CareLine. The CareLine provides referral information (including housing and other resources) through the statewide 211 number. The Bannock Youth Foundation (Pocatello) and Hays Shelter Home (Boise) provide federal grant funded crisis and emergency shelter to runaway and homeless youth; these programs coordinate mental health care needs with CMH. The Division’s CMH program and the Department of Education collaborate with local school districts to implement intensive community and school based programs. All 114 independent Idaho local school districts respond to the Individuals with Disabilities Education Act (IDEA) for eligible children. IDEA services include child find/referral, evaluation/eligibility, individualized education plans (IEP), related services, least restrictive environments, review and re-evaluation, transition requirements and consideration of behavior management needs.

The Division works collaboratively with juvenile corrections programs in several ways. Clinicians are placed in juvenile detention centers to assist with evaluations, service referrals and crisis counseling. The Juvenile Justice/Children’s Mental Health (JCMH) collaborative workgroup focuses on resolving obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored implementation of a Youth Mental Health Court in three counties (as of July 2011) with interest in expansion to other counties. The Youth Mental Health Court uses the wraparound service model to facilitate treatment planning and coordination. The SUD prevention staff also participates on the juvenile corrections sponsored Enforcing Underage Drinking Laws workgroup. This partnership enables Idaho to reduce duplication and increase effectiveness in service delivery to this population.

Local substance use disorders (SUD) services for adults and children are provided through an array of private treatment providers. The Management Services Contractor, BPA, manages this array of SUD treatment providers and prior authorizes services. Business Psychology Associates are also responsible to conduct SUD utilization reviews and provide data to the Division for state and federal reporting. Outpatient and inpatient services are available to residents in every region, but they are not necessarily located in every region. Three Pregnant Women and Women with Dependent Children (PWWC) specialized SAPT providers offer arrangements for prenatal care. Few services are available to parents with mental illness who have dependent children. Youth 15 years and under are required to have parental consent for services, while those 16 and older can access treatment services without parental consent. Services for children and youth who are diagnosed with SED and a substance use disorder (SUD) are delivered by two different Division of Behavioral Health programs. The CMH comprehensive assessment includes assessment of substance use and service recommendations. The majority of CMH services (mental health and substance abuse) are delivered by private providers. For children and youth diagnosed with SED and a developmental disability, services are coordinated through the Department’s Division of Behavioral Health and Division of Family and Community Services.

Benchmark Research and Safety (BSR) is responsible to conduct SUD prevention utilization reviews and provide data to the Division for state and federal reporting. Substance abuse prevention strategies include information dissemination, education, alternative activities, problem identification and referral,
community based processes, environmental strategies. Prevention information dissemination is
conducted through distribution of the Idaho RADAR Network Center’s materials and video library to
community members, coalitions, schools, prevention/treatment programs, social services/health care
providers and other stakeholders and through the Idaho Preventing Underage Drinking campaign.

Education is provided to groups and individuals identified in the DHW needs assessment as having one or
more risk factors (i.e., Hawkins and Catalano Risk & Protective Factors). The Division’s contract with
BRS funds community based prevention providers’ delivery of evidence based programs to universal,
selective and indicated audiences (see www.preventionidaho.net for details). Alternative activities are
funded based on needs assessment identified risks. Community based providers contracting with BRS
offer drug free activities and support services to universal or selective youth and families (e.g., after­
school programs, mentoring, modeling positive behaviors). Problem identification and referral services
are also delivered by community-based providers with the goal of identifying at-risk children early and
referring them to services needed to reduce their risk of substance use. Community based processes are
delivered by community coalitions through BRS prevention contracts. The Community Coalitions of
Idaho (CCI) receive Division technical assistance and support to address risk factors identified in their
respective communities. Environmental strategies are undertaken by community coalitions receiving
block grant funds. The SSA also supports an annual media campaign targeting parents in an effort to
reduce underage drinking.

Results of the 2011 legislative session included changes to the SFY 2012 state cost/general fund
allocation for the Division’s SUD funds to compensate for the loss of multi-agency coordination funds
with the sunset of the Interagency Committee on Substance Abuse in June 2011. A total of $625,200 was
shifted to the Department of Correction for felony substance abuse treatment; a total of $3,232,900 of
dedicated substance abuse treatment funds was shifted from the Division’s SUD program to the Judicial
Branch for substance abuse treatment for drug and mental health courts; and a total of $4,032,000 was
shifted to the Department of Juvenile Corrections budget for juvenile offender substance abuse treatment.

Legislators decreed that the Department of Health and Welfare would retain responsibility for adult
misdemeanant treatment, Medicaid recipients, SAPT Block grant priority populations and community­
based prevention.

The purpose of the Olmstead Act is to ensure that individuals who no longer need institutional level care
are able to move into less restrictive community based settings. As of July 2011, the State of Idaho did
not have a formal Olmstead Plan. Over the past three years, Idaho’s allocation of federal Olmstead Grant
funding has gone toward supporting the Peer Specialists programs through Mountain States Group.
Idaho’s new “Money Follows the Person” Program has similar goals to the Olmstead act with respect to
assisting with community placements in lieu of institutions. The program that Idaho is adopting is called
the Home Choice Program. This program is federally funded and allows for Transition Managers to help
assist adults diagnosed with developmental disabilities or mental illness who no longer need institutional
care to transition into the level of community based care that best meet their needs.

Medicaid benefits plans include the Medicaid Basic Plan Benefits, the Medicaid Enhanced Plan Benefits
and the Medicare/Medicaid Coordinated Plan Benefits were effective as of July 1, 2006. The Medicaid
Medicare Coordinated Plan was effective April 1, 2007. Blue Cross of Idaho started with their plan on
April 1, 2007 and United Health Care started with their plan on May 1, 2007. Partial Care, Service
Coordination and Psychosocial Rehabilitation mental health services are excluded from the Medicaid
Basic Plan Benefits except for diagnostic and evaluation services to determine eligibility for these
services. These services continue to be covered under the Medicaid Enhanced Plan Benefits. The
services available in the Medicaid Enhanced Plan include the full range of services covered by the Idaho
Medicaid program. One major policy change in SFY 2008 expanded Medicaid eligible locations for
service delivery to allow physicians to perform telehealth in any setting in which they are licensed.
Several strategies were implemented in an effort to control rising Medicaid mental health service costs. In 2009, the number of Medicaid partial care hours was reduced from 36 to 12 per week, Psychosocial Rehabilitation (PSR) services were reduced from 20 to ten hours per week, and PSR crisis services were reduced from 20 to ten hours per week. The Medicaid Management Information System (MMIS) was implemented in May 2010 to address data needs related to claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals.

Legislation and relevant Idaho Code changes in SFY 2010 that pertained to rules governing Medicaid included House Bill (HB) 701 that provided legislative intent for Medicaid program flexibility for FY 2011. The 2010 Idaho State Legislature approved Rules Governing Medicaid Cost-Sharing (IDAPA Chapter 16.03.18) that described the sliding scale, premium payments and premium waivers. As noted on page 26, “The cost savings for this rulemaking for SFY 2010 is estimated at $210,000 in state general funds.” Medicaid Omnibus Bill (HB 708) continued pricing freezes from SFY 2010 through SFY 2011; this bill allowed additional budget reductions that included mandates for pharmacies to participate in periodic cost surveys. In SFY 2011, House Bill 260 reduced State Medicaid spending by $34.6 million, which translated to a total reduction of $100 million with the additional loss of matching federal funds. As of July 2011, Medicaid was pursuing a contract with a managed care organization (MCO) with a target implementation date of 7/1/12 for the administration of mental health benefits. A 1915b waiver will be in place as the funding authority to support the MCO contract. Qualis signed a three year contract renewal with Medicaid in June 2011 to provide case management and utilization management services.

The Division of Behavioral Health is able to extend services through an assortment of federal SAMHSA grants. The SUD program’s Access to Recovery (ATR) grant serves military (includes veterans, military reserves and Idaho National Guard), adolescents re-entering the community from state and county institutions (e.g., juvenile detention, state run correctional, hospitals) and adult supervised misdemeanants. Services include intensive SUD outpatient, safe and sober housing for adults and adolescents, case management, drug testing, transportation, child care, and life skills education. The Projects for Assistance in Transition from Homelessness (PATH) grant allows for outreach to adults with serious mental illness who are homeless. The CMHS Transformation grant, the Idaho Home Outreach Program for Empowerment (ID-HOPE) supports provision of evidence based Critical Time Intervention (CTI) services in pilot Regions 3 and 4. Idaho’s data infrastructure development efforts receive federal support through a transformation grant directed to implementing a data warehouse and through the Data Infrastructure Grant (DIG) that focuses on WITS development to collect and report on the National Outcome Measures (NOMS). Idaho’s prevention data capacity has been significantly increased by the State Epidemiological Outcomes Workgroup (SEOW) grant, which funded the Division’s development of the Idaho Prevention and Treatment Research website (www.patr.idaho.gov). This website provides county level risk-factor data to enable community coalitions and other interested individuals and groups to easily access substance abuse-related data.

Regional, County and Local Entities that Provide Behavioral Health Services or Contribute Resources

Idaho Code Section 19-2524 (effective SFY 2007), gives judges additional sentencing options for felons with substance abuse and mental illness diagnoses. The law allows a judge to order a substance abuse assessment and/or a mental health examination for felons and felony parole violators that appear before the court. Based on the results of an assessment or examination and as a condition of probation, a judge may order the defendant to undergo treatment consistent with the treatment plan (subject to modification by the court) contained in the assessment or examination report.

The priority adult populations to be served through the public mental health service system are 1) adults who are in crisis, 2) court ordered commitment to the Department (66-329 and 18-211/212), 3) Court ordered evaluation and treatment for offenders sentenced under criminal court (Idaho Code 19-2524), 4)
mental health court referred individuals and 5) outpatient services for those who have no insurance or other resources. Regional Mental Health Courts refer individuals to treatment through Assertive Community Treatment (ACT) programs. While regional programs may continue to retain some eligible individuals who have Medicaid and who are unable to be served in the private sector because of challenging needs or behaviors, efforts are being made to refer all Medicaid eligible individuals to private community resources. The priority children’s populations to be served through the public mental health system are 1) children and families in crisis, 2) court ordered evaluation and treatment for juveniles ordered by the court or through Juvenile Mental Health Court (see ID Code 20-511(a), 66-321, 18-211/212, and 3) outpatient services for those who have no other benefits.

The Division of Behavioral Health collaborates with the Social Security Administration to encourage collaborative efforts to educate Idaho providers about their system and to train them in SSI/SSDI Outreach, Access and Recovery (SOAR). This training helps providers to facilitate more effective completion of eligible client SSI/SSDI benefit applications. The Division of Behavioral Health includes two staff trained in the SOAR benefits skills. These SOAR trainers began providing SOAR trainer to Idaho behavioral health providers in March 2011.

The Division has an Interagency Agreement with the Idaho Division of Vocational Rehabilitation. This Agreement supports the placement of a vocational rehabilitation (VR) counselor at each of the regional CMHC sites. The VR counselor is responsible to attend at least one weekly ACT team meeting. Often, the VR counselor attends more than one weekly ACT meeting and may also attend weekly mental health court meetings that relate to shared clients.

The Division is represented at monthly community networking meetings sponsored by the courts for the purpose of exploring the feasibility of creating a veteran’s court. These meetings include representation from the courts, behavioral health treatment providers, the veteran’s administration, law enforcement and other stakeholders. The veteran’s group anticipates implementing a veteran’s court in SFY 2012.

An ad hoc committee designed to identify treatment needs and resources for military populations meets at least quarterly. Representation includes the Idaho National Guard, the Division of Behavioral Health, behavioral health providers that contract with the Idaho National Guard and other stakeholders.

The Division meets regularly with the Department of Juvenile Corrections sponsored Enforcing Underage Drinking Laws workgroup. Representation on this workgroup includes Departments of Education and Transportation, the Liquor Division, the Idaho State Police, the Idaho College/Universities Coalition and Idaho Prosecuting Attorneys Association. This workgroup addresses issues identified by member agencies. In SFY 2011, workgroup efforts were instrumental in targeting parents to work with their children and adolescents to reduce underage drinking.

How Systems Address Needs of Diverse Racial, Ethnic and Sexual Gender Minorities

The 2010 Census Bureau estimates 89.1% of Idaho citizens self-identify as white; 84% as White/not Hispanic; .6% Black, 1.4% American or Alaska Native; 1.2% Asian; 0.1% native Hawaiian/Pacific Islander and 11.2% Hispanic/Latino origin. Regions 3 and 4 contain the largest concentrations of individuals with Hispanic heritage, with up to 15% of the population.

Cultural issues are addressed through learning applications available to all staff on the Department of Health and Welfare’s Knowledge Learning Center (KLC) website, but this does not address specifics related to Native American tribes or Gay, Lesbian, Transgender, Bisexual or Questioning (GLTBQ) populations. The Idaho Minor in Prevention Curriculum includes attention to culture, age and gender.
Literacy is addressed during service delivery, and materials may be read to the individual if they are unable to read. Regional service information and treatment materials are available in English and Spanish in Behavioral Health offices, and other languages can be addressed through translator resources. The 2011 Idaho Conference on Alcohol Drug Dependency (ICADD) offered a session on elements of culture.

With respect to GLTBQ populations, Annual Gay Pride week celebrations are held in the Treasure Valley (Region 4) and the Magic Valley (Region 5). The Boise Gay and Lesbian Community organizations in Idaho host educational and supportive websites at http://tccidaho.org (Boise) and http://sites.google.com/site/gayidahofalls/ (southeastern Idaho and Idaho Falls). Other websites are available to identify counseling resources that specialize in GLTBQ issues and services.

Idaho’s six federally recognized tribes are the Shoshone Bannock, the Northwest Band of the Shoshone, the Nez Perce, the Coeur d’Alene, the Kootenai and the Duck Valley (Shoshone Paiute) Tribes. The Division of Behavioral Health’s Substance Use Disorder provider network includes the tribally owned Benewah Medical and Wellness Center in northern Idaho (Plummer), but interaction with the Division on SUD treatment services is limited to the facility renewal process. Behavioral Health efforts to engage Tribal leaders would likely evolve into meetings between the Division of Behavioral Health and Tribal Mental Health and Substance Abuse programs. The Division provides funds to Benchmark Research Safety to contract with tribal organizations or school districts on tribal lands from three Idaho Tribes (i.e., Shoshone Bannock, Nez Perce and Kootenai) for SUD prevention programs.
Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Thomas Long requested additional detail as follows:

There is no mention of what **specific services are being provided to IV drug users and individuals with TB** as discussed on page 20 of the instructions.

Please see below for additional detail on specific services provided in Idaho to IV drug users and individuals with TB:

**IVDU**

The Management Services Contractor, Business Psychology Associates (BPA), through its network of approved substance use disorder treatment providers, is required to provide services to individuals identifying themselves as an intravenous drug user (IVDU). Through the screening process IVDUs are identified as priority clients and given the first available treatment appointment. When an IVDU calls requesting services, BPA has the ability to connect the client with the program closest to them with space available, or connect them to other programs throughout the state with space available. The care manager can authorize treatment or interim services at a lower level of care until space is available in the ASAM PPC 2R indicated level of care. Using their management information system, BPA tracks the dates that 1) an IVDU is screened, 2) services are authorized and 3) services are first delivered to verify that IVDU’s are cleared and referred for placement within fourteen (14) days of screening. The Department maintains a protocol for reporting and provision of interim services for IVDUs at the service contractor level. Business Psychology Associates is required to notify the Department when their network providers are at 90 percent of capacity. In Idaho, the number of IVDUs, particularly HIV positive individuals, is historically low, and the Department has had no problem meeting the federal requirements for admission of IVDUs to treatment.

**TB**

The Care Management component of BPA oversees treatment planning and ensures that appropriate, comprehensive services are provided for all treatment needs identified in the comprehensive assessment, including referral to TB screening and treatment. BPA’s regional coordinators are dedicated to the oversight of services provided to enrolled clients, including those relating to TB. Counselors at the program level are responsible to ensure that clients receive care for identified treatment needs, including those relating to TB. They are also responsible to refer clients to ancillary services that are not provided directly by the program.
With the implementation of the WITS electronic record system, the Department will be able to collect data during admission. Data will include whether or not a client has had a TB test in the past and what the results of that test were. The target date for entering all new substance use disorder clients into the WITS system is July 1st, 2012.
II: Planning Steps

**Step 2: Identify the unmet service needs and critical gaps within the current system**

*Page 22 of the Application Guidance*

**Narrative Question:**

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

**Footnotes:**
Identification of Idaho’s Unmet Service Needs and Critical Gaps

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State’s behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority. The State’s priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA’s data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving. In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Identification of Data Sources Used to Identify Needs and Gaps

Idaho’s behavioral health unmet service needs and critical gaps are based on data from multiple sources. These numbers represent Idaho’s best estimate to date of incidence, treated prevalence, and quantitative targets. Data represents our best estimates based on available data and reflects the limitations of our reporting and information systems. In some cases it is not possible to guarantee unduplicated counts. These numbers represent publicly provided and/or funded (including Medicaid) mental health services rendered by the public sector. Some individuals received services from both public mental health system and private sector providers during FY2011. As of July 1, 2011, numbers served for adult mental health and children’s mental health were captured in the Division’s WITS system.

The State of Idaho uses the estimation methodology for adults and children required by the Substance Abuse Service Administration’s Center for Mental Health Services (CMHS) and the National Prevalence figures prepared for MHSISP by the National Research Institute and distributed by CHHS to determine prevalence of Serious Mental Illness (SMI), Serious and Persistent Mental Illness (SPMI), homeless with SMI and children with Serious Emotional Disorders (SED). Background details on the definition for SMI were published previously in the Federal Register on May 20, 1993. Estimation methodologies were published in the Federal Register on June 24, 1999.

The Web Infrastructure for Treatment Services (WITS) system was implemented 10/1/09 for collection of Adult Mental Health (AMH) data for public services provided through regional mental health center (RMHC) sites. Implemented in SFY 2009, the VistA data infrastructure system is used by State Hospital South (SHS) and State Hospital North (SHN). The Division of Behavioral Health (DBH) has an Interagency Agreement with the Idaho Division of Vocational Rehabilitation (IDVR), and employment data is also collected from IDVR. The Office of Consumer Affairs (OCAFA) provides monthly reports of services for Consumer and Family Advocacy/Education, Peer Specialist Certification and PATH activities provided by PATH peer specialists. Children’s mental health data has historically been collected and reported from the FOCUS system, but DBH is in the process of enhancing the WITS system to allow data collection and report extraction from WITS. Consumer survey information is based on annual and end of service MHSISP and YSS-F survey requests. In an effort to support and crosswalk data from WITS, VistA and SUD data sources, DBH is also working on development of a data warehouse with a target implementation data of SFY 2012. Medicaid data must be requested. Medicaid’s contract with the data management vendor, Molina, began in May 2010. This system handles Medicaid service and billing data.

The Substance Use Disorders (SUDS) program also gathers and reports data from several sources. The National Survey on Drug Use and Health (NSDUH) provides Idaho specific data to evaluate incidence and prevalence of substance use and abuse and to estimate populations in need of substance use disorders services. The Division of Health implements the Youth Behavioral Risk Survey (YRBS) and the Behavior
Risk Factor Surveillance System (BRFSS), and this data is useful for substance use disorder needs assessments and planning. Substance use disorder service provider treatment data is collected by the Management Services Contractor, Business Psychology Associates, and uploaded to the Department. The SUD treatment data is used to create a number of standard reports that are utilized for State planning and assessment. Standard reports include State Utilization Management and Grant Data; Level of Care Capacity and Census Management; Budget Tracker; Treatment Completion Data; Length of Stay Report; County/Regional Utilization Report; Pregnant Women With Children (PWWC) Chart Audit Results and Client, Provider & Stakeholder Satisfaction reports. Each of the seven regions in Idaho has a Regional Advisory Committee (RAC) that provides an annual report and updated information to help determine regional and local needs, emerging trends, gaps in service and the need for programs and services in regions throughout the State. The SUD system is also working with the vendor, FEI, to develop the WITS system for SUD use. The Department plans to conduct monthly meetings with other state agencies during SFY 2012-2013 to assess and plan for SUD treatment needs and services. During SFY 2012-2013, the Department will continue to use the NSDUH, the Treatment Episode Data Set (TEDS), YRBS, BRFSS, substance use disorder treatment data and information from the RACs to assess SUD treatment needs in Idaho.

The Department’s contract with Chestnut allows for the Global Appraisal of Individual Needs (GAIN) SS to be used for all client screenings and the GAIN-I for all clinical assessments. Chestnut Health Systems (Dennis, M. & Modisette, K.) created a PowerPoint presentation entitled “A Profile of Idaho’s FY10 Data from the Global Appraisal of Individual Needs (GAIN)” for the Idaho Office of Drug Policy in January 2011 (see attachment). The PowerPoint states that “This presentation uses data collected by Idaho providers as part of the state mandate to use a common assessment across programs.” Authors add, “In 2009 staff started using version 5.6 with a web-based software to assist with the interviewing … Data used here are 4,815 clients intaked by 51 providers collected in fiscal year 2010 (7/1/2009 – 6/30/2010).” This evaluation provides one source of information for assessment of unmet SUD needs and gaps at the State, local and provider levels, however it must be noted that the data provided does not identify clients by region or provider, nor does it account for differences in counties or service areas across the State.

The Idaho State Epidemiological Outcomes Workgroup (SEOW) is composed of state agency staff and other community stakeholders (Idaho Prevention Fellow, researchers) with an interest in the substance abuse treatment and prevention system. In regards to treatment and prevention, the SEOW operates as an ad hoc research resource for policy decision makers. Additionally the group maintains a web dissemination resource for more general data related questions. On the State level, the SEOW is identified as the Idaho Prevention and Treatment Research (PATR) work group. The PATR website at http://patr.idaho.gov/ states that “The Idaho Prevention and Treatment Research (PATR) Workgroup exists to develop a system of substance abuse related data collection, analysis and reporting that reflects substance abuse consumption and consequences throughout Idaho.” This public site is accessible to all Idaho stakeholders and reflects 15 risk factors, 44 counties and 1,980 data points. Collected at the county level, the PATR website risk factor data (updated at least once every two years) is a resource for state agencies, communities and coalitions needing data to develop substance abuse (including underage drinking) or other plans for their specific needs. Data graphed by county on this site is based on Hawkins and Catalano’s (1992) risk factors. Data reflects domains related to school (i.e., incidents of bullying, suspensions, truancies), individual (i.e., adolescent pregnancy, juvenile arrests for alcohol related charges and juvenile arrests for drug related charges), family (child abuse and neglect, heavy drinking, illicit drug use), and community (i.e., adult arrests for alcohol related charges, adult arrests for drug related charges, free or reduced school lunch eligibility (K-12), impaired driving crashes, per capita sales of distilled spirits, unemployment rate). The PATR website uses data provided by the Idaho Liquor Division, the Idaho State Police and the Idaho Departments of Education, Transportation and Health and Welfare. The State of Idaho Epidemiological Profile of Substance Abuse 2010: State Epidemiological Outcomes Workgroup Report and the updated 2011 Report are attached.
The Division of Behavioral Health’s SA/SUD program contracts with Benchmark Research and Safety, Inc., to serve as the Idaho SA prevention system manager. Benchmark manages the community based prevention system. This includes annual state and regional needs assessments used to identify at-risk populations and underserved areas. Community based providers are able to utilize this data to secure funding for populations that need services in their respective communities.

Other behavioral health assessments were completed by the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) and the Governor’s Transformation Workgroup. The ICSA workgroup’s assessment resulted in a document entitled “Idaho Substance Use Disorder Prevention and Treatment System: A Collaborative Strategy for 2008-2012. It indicates that “The System addresses individual, community and tribal needs statewide for effective and accessible prevention, education, assessment, early intervention, treatment, recovery support services and post-treatment support,” (p. 3). It adds that the “System strives to maintain an uninterrupted, well-coordinated continuum of services to clients and their families within and outside of the criminal justice system.” Identified needs in the ICSA plan that were not complete by July 2011 (Appendices, p. 3, pp. 9-11) included collaboration with local and state correctional agencies and detention facilities to develop shared resource methods to ensure effective implementation and delivery of intervention and treatment services to adult and juvenile populations in correctional and detention facilities and collaboration with the Department of Education to implement core best practice and outcome measures for prevention services in K-12. Other goals included collaboration with the Department of Health and Welfare to 1) assure a provider network to balance service availability and funding throughout the state; 2) identify core evidence based practices by population; and 3) work with the Idaho Department of Correction and Juvenile Corrections and county probation to identify protocols to integrate treatment with probation services.

The Idaho State Planning Council on Mental Health’s 2011 Report to the Governor and State Legislature: Idaho Mental Health at the Crossroads (June 2011) document identifies critical gaps related to increased suicides, increased use of law enforcement and increased use of hospitals. Recommendations include identification of sustainable funding to support an Idaho Suicide Prevention Hotline; full funding for mental health services and priority on Crisis Intervention Training (CIT) for law enforcement; and adoption of the “…principles of the 10 X 10 SAMHSA Plan to support the need for a full continuum of care for people with mental illness services in their own communities, for both physical and mental health, thereby preventing costly hospitalizations, and supporting the system of recovery.”

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff’s Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision; “Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery. Goals included the following; 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

The BHTWG’s efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho’s Behavioral Health System (October 28, 2010). This report’s recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council to the State Behavioral Health Council; establish the Behavioral Health
Governor Otter signed Executive Order 2011-01 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership is at the pleasure of the Governor and includes representation from the Department of Health and Welfare, the Office of Drug Policy, the Department of Correction, the Department of Juvenile Corrections, the State Mental Health Planning Council, Administrator of Idaho Courts, the Superintendent of Public Instruction and one representative of the counties. One purpose is to “d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho’s Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho’s budget, current needs of the agencies, and recommendations of the Idaho Health Care Council.” As of 5/13/11, the IBHIC “to do” list was broken into four phases. Phase 1 included finalizing Phase 1 funding; planning regional behavioral health development boards and state behavioral health planning council (e.g., identifying proposed membership, proposing an implementation timetable, soliciting and reviewing input and drafting legislation to implement regional behavioral health development boards to submit to the 2012 legislature); establishing core services for all regions and drafting 2012 legislation proposals; developing a transformation work plan, communications protocol and proposed transformation activity funding for SFY 2013; review SUDS treatment services and data report elements and prepare a status report for the Governor. Phase 2 included determining available Phase 2 funding and resources; finalizing core services standards for the transformed behavioral health system;
initiating regional transformation efforts, coordinating transformation activities with health care reform activities and preparing a status report for the Governor. Phase 3 included determining available Phase 3 funding and resources; developing a Transformation Implementation Plan that applies to all Cooperative entities; developing regional Transformation Implementation Plans; monitoring and evaluating phase-in and recommending adjustments to State and Regional Transformation Plans; coordinating transformation activities with health care reform activities and preparing a status report for the Governor. Phase 4 included determining available Phase 4 funding and resources; continuing phase-in of transformation, drafting legislation to implement the next phase; coordinating transformation activities with health care reform activities and preparing a status report for the Governor.

Unmet Service Needs and Critical Gaps
According to the U.S. Census Bureau data for 2010, Idaho total population estimate was 1,545,801, with an estimate of 1,126,894 aged 18 or older and an estimate of 418,907 under age 18. Based on this data and the SAMHSA/CMHS estimation methodology establishing prevalence for adults at 5.4% for SMI, 2.6% for SPMI, 5% of the estimated SMI population as homeless and 5% for children/adolescents, it may be concluded that there are 60,852 adults in the state of Idaho with serious mental illness, 29,299 adults in the state of Idaho with serious and persistent mental illness, 3,043 adults with SMI who are also homeless and 20,945 children with serious emotional disorder diagnoses. Idaho’s TEDS data for 2008 indicates a treatment admission rate of 5,683 aged 12 and older; an estimated 464 admitted per 100,000 population aged 12 and older; 2,110 primary alcohol admissions and 1,712 primary marijuana admissions. This data indicates that, for the total of 5,683 admissions 12 and older in 2008, 48.9% were regular outpatient and 40.2% were intensive outpatient; 11.1% detoxification services were free-standing residential; 5.9% residential services were short-term and .03% were long-term; 1.1% of opioid treatment was outpatient, .1% was detoxification and .2% was residential.

Unmet service needs and critical gaps in Idaho’s system of care relate to suicide, homelessness and residential/transitional options, employment, mental health (MH) and SA/SUD prevention, data infrastructure development and linkage, access to care (e.g., for those without criminal charges, primary health care resources for medical and dental needs, rural and frontier areas), cultural competency related to specialty populations, seamless service delivery for youth transitioning from children’s services to adult services and recovery and resilience opportunities. These needs and gaps will be described in further detail below.

Suicide: There is no nationally certified suicide prevention hot line in Idaho. The National Suicide Prevention Lifeline reported 3,700 calls from Idahoans in 2010. The Suicide Prevention Action Network of Idaho (SPAN Idaho) provided a suicide fact sheet in July 2010 based on data from the Idaho Bureau of Vital Records and Health Statistics, the Idaho Department of Health and Welfare, the Centers for Disease Control and Prevention and YRBS Idaho (see attached). According to these statistics, suicide is the 2nd leading cause of death for Idahoans 15-34 and for males 10-14 years of age. The fact sheet reports that in 2009, 307 people completed suicide, with 77% by men, and 58% involving a firearm. Also in 2009, “14.2% of Idaho youth attending traditional high schools reported seriously considering suicide in 2009,” with 6.9% reporting at least one attempt. The State Planning Council on Mental Health identified this as a top June 2011 concern. The Chestnut report of SUD client data from GAIN results for SFY 2010 (January 2011; see attached) indicated that 59% of the sample population reported co-occurring psychiatric problems, 28% reported major depressive disorder, 22% reported traumatic stress disorder, 61% reported a history of physical, sexual or emotional victimization, and 23% reported homicidal/suicidal thoughts in the past year. The SEOW report for 2010 (see attached, p. 10-11) indicates that “Idaho’s suicide rate (2005) was 45% greater than the national rate.”

Housing and Homelessness: Homelessness remains an area of concern in Idaho. The website (http://www.endhomelessness.org/section/about_homelessness/cost_of_homelessness) for the National Alliance to End
Homelessness indicates that Idaho had a 32% increase in homelessness from 2008 to 2009, with an estimated total of 1,939 homeless individuals in 2009. The Idaho Housing and Finance Association’s (IHFA) January 2011 Point in Time count estimates 2,199 homeless individuals statewide. Homeless students in Boise school districts was estimated at 1,717 in the 2009-2010 school year (ie., Nampa 757; Boise 656; and Meridian 304). In the Coeur d’Alene School District, 248 of the roughly 10,000 total students were identified as homeless in spring 2010. Project Safe Place provides services to teenagers in crisis at 78 locations spread around the greater Coeur d’Alene area. This program’s services include a drop-in center, drug prevention education, crisis intervention and emergency shelter for youth under 18.

Prior to SFY 2011, the Projects for Assistance in Transition from Homelessness (PATH) grant divided PATH funds among seven Regional Mental Health Centers. The Idaho PATH Annual Report for 2009 indicated that, of the estimated (i.e., 5% of estimated SMI) 2,947 adults who were homeless with SMI, there were only 702 PATH clients served with federal, state and other funds (not including federal funds to Idaho Housing and Finance Association or Boise Ada Housing Authority that provide limited assistance to adults with SMI). In SFY 2011, the PATH grant contracted with other providers. The contract with St.Vincent de Paul in Coeur d’Alene was directed to provision of homeless services to adults diagnosed with a serious mental illness in that catchment area. The majority of PATH funds went to a contract with Mountain States Group’s Office of Consumer and Family Affairs (OCAFA) to hire, train and supervise Certified Peer Specialists to provide up to 75% active face to face outreach to homeless adults with SMI. Two PATH Peer Specialists, each working 19 hours per week, were trained and began to provide PATH outreach in April 2011.

The Idaho Home Outreach Program for Empowerment (ID-HOPE) project was funded through a CMHS transformation grant and the evidence based practice of Critical Time Intervention (CTI) began in pilot regions 3 and 4 in March 2011. The ID-HOPE team is composed of a mix of Certified Peer Specialists and bachelors/masters level staff. This team includes specialists in housing and crisis services. In May and June, 2011, PATH and ID-HOPE team members participated in the PATH to Housing phone and webinar technical assistance course offered by the Centers for Social Innovation. Idaho is also in the process of establishing Safe and Sober housing for adolescents in Regions 1, 3 and 4. While there is some concern about funding, initial costs will be covered through the Access to Recovery (ATR) project. Sustainability of these resources is a concern. The Chestnut study (January 2011) indicated that 39% of the SFY 2010 sample reported environmental stressors related to housing.

While Idaho has homelessness services, safe, decent and affordable Idaho housing resources are more difficult to access and retain for individuals diagnosed with mental health and/or substance use disorders. The Idaho Housing and Finance Association (IHFA) announced in April 2011 that it was no longer accepting applications for Shelter Plus Care, with an anticipated wait of 18 months or more before this resource would again be available. Landlords are often reluctant to rent to individuals with behavioral disorder diagnoses. Adolescent SUD residential facilities and/or transitional living resources have historically included funded from the Division of Behavioral Health and Idaho Division of Juvenile Corrections (DJC). Decreased funding for both programs has made it difficult to support the costs for the number of beds and bed days that are needed.

**Employment:** The Idaho Department of Labor reported an unemployment rate of 9.4% for May 2011, with an estimate of Idaho workers without jobs below 72,000 for the first time in nine months. The June 2011 report described variability in employment among Idaho counties. This report states that “Seventeen primarily rural counties posted double-digit unemployment rates, down from 18 in April. Two major urban counties remained in double-digits.” While jobs are hard to find for the general Idaho populace, they are even harder to find and keep for those with mental health and/or substance use disorder diagnoses.
Prevention: Idaho has limited substance use prevention funds and no identified funding for mental health prevention (as of July 2011). Idaho uses the required 20% of the Substance Abuse Prevention and Treatment (SAPT) block grant to fund a range of Substance Abuse (SA) prevention services, but funds do not adequately meet the need. As of July 2011, there were no other state agencies funding primary substance abuse prevention activities. In Idaho, the Division of Behavioral Health’s prevention database identifies the location of prevention services. Coalition information is determined from the Community Coalition of Idaho’s membership list. According to these data sources, 49% of Idaho cities have no SA/SUD community-based prevention; 47% of school districts have no SA/SUD prevention and 61% of counties have no SA/SUD coalitions. According to the Idaho School Climate Survey (2006), 13.4% of 6th grade children report past month binge drinking. The YRBS results indicate that 24% of 11th grade males reported binge drinking in the past month, over 50% of high school seniors reported past alcohol use and one in three high school students reported that they had tried marijuana in the past. The Chestnut study (January 2011) indicated that results of their sample showed a pattern of weekly substance use (13+/90 days) of alcohol 16%; cannabis 15%; cocaine 1%; opioid 8%; amphetamine 12%; other drugs 4%; needle use 16%; and tobacco 69. The 2010 SEOW report indicates that the percentage of drugs analyzed at the National Forensic Laboratory for Idaho includes approximately 48% methamphetamine, 39% marijuana and 4% cocaine.

Regarding mental health prevention, the Office of Consumer and Family Affairs (OCAFA) provides education on mental health issues, but there are no formal prevention efforts, programs or policies for Adult Mental Health (AMH). While the Children’s Mental Health (CMH) program participates in anti-stigma awareness campaigns and the annual Children’s Mental Health day, there are no ongoing, formal prevention efforts or policies in CMH. Prevention efforts are historically more beneficial and more cost effective than more intense treatment services. In addition to being less stigmatizing, community based services are significantly less expensive than hospitalization, jail or residential options.

Data Infrastructure: The Division of Behavioral Health continues to focus on development of a strong data infrastructure system capable of both collecting and extracting required data for local, state and federal reports and producing outcome data to guide resource decisions and best practice. The WITS system was implemented for Adult Mental Health (AMH) in October 2009, with current efforts on developing WITS for Children’s Mental Health (CMH) and Substance Use Disorders (SUD) service needs. Requirements for a data warehouse capable of assisting with the interlinking of behavioral health data with the state hospitals’ VistA and other systems were addressed in SFY 2011, with a planned data warehouse completion in SFY 2012. The WITS system does not link to data systems for Medicaid, courts, criminal justice, primary health, schools, community hospitals or Idaho Vocational Rehabilitation. Specific requests must be made to access data from these data resources, and their data is not necessarily based on the same data element definitions as that used by the Division of Behavioral Health’s WITS system. As of July 2011, there was no resource that captured co-morbidity data for behavioral health and physical health diagnoses, and this lack of data complicates efforts to accurately assess need. The SUD prevention program uses a web-based system with secure and non-secure portions (see www.preventionidaho.net ) to collect data on participant demographics, attendance, pre/post test scores, providers/staff and staff training. This site is also used for collection of required block grant and NOMS data, for providing information to contracted prevention providers, for accessing needs assessment reports and for locating funded prevention services.

Access to Care: Additional unmet needs relate to access to care. As of July 1, 2010, the priority population for mental health was adults in crisis and those referred through the court system. The priority population for SA/SUD included pregnant IV drug users and court ordered individuals. Access to behavioral health care for those without criminal charges is difficult in a context of limited funding. Access to primary medical and dental care resources and services can be difficult as well. The rural and
frontier nature of Idaho’s geography poses additional challenges with respect to transportation and to attracting and retaining health professionals.

The Chestnut study (January 2011) indicated that the SUD GAIN sample from SFY 2010 results suggested that biomedical common treatment planning needs included risky sex behavior 82%; tobacco cessation 68%; accommodation of medical conditions 39%; medications for physical health problems 26%; and current treatment for medical problem 26%. Some private providers (e.g., Terry Reilly Health Services) provide low or no cost services to those without insurance or means to pay. There are more people who need Medicaid dental services than there are Medicaid dental providers.

Steven Snow, Executive Director of Idaho’s Council for the Deaf and Hard of Hearing indicates that the deaf and hard of hearing in Idaho don’t have access to services that adequately address deaf and hard of hearing needs. According to Steven, there is only one person in Idaho who signs and provides mental health counseling services. Steven suggests that the lack of access to adequate behavioral health services negatively affects the quality of life for deaf and hard of hearing Idaho citizens. The Council for the Deaf and Hard of Hearing has plans to implement a task force to identify needs for mental health, substance use, domestic violence and other issues in SFY 2012.

With respect to justice system involvement (JSI), Chestnut (2011) results indicated that the percentage reporting detention/jail for 30+ days was 26%; detention/jail for 14-29 days was 8%; probation/parole for 14+ days with one or more drug screens was 25%; other probation/parole/detention was 16%; other JSI status was 13%; and past arrest/JSI status was 8%. According to Idaho State Police data in the 2011 SEOW report, there were 7.99% Idaho DUI and other alcohol related arrest rates per 1,000 population in 2009, and 8.62% per 1,000 population were arrested for possession.

Idaho is composed primarily of rural and frontier areas, and increased gas prices make it even more difficult for Idaho citizens to keep appointments with service providers that may be up to an hour away by car. In SFY 2008, there were two major changes in Medicaid. Policy changes expanded eligible locations for service delivery to allow physicians to perform telehealth in any setting in which they are licensed. A benefit was added to allow for family therapy without the client present.

Cultural Issues: Cultural issues are addressed through learning applications on the Department of Health and Welfare’s Knowledge Learning Center (KLC) website, but this does not address specifics related to Native American Tribes or Gay, Lesbian, Transgender and Bisexual populations. The Idaho Minor in Prevention Curriculum includes attention to culture, age and gender. Service information and treatment materials are available in English and Spanish in regional Behavioral Health offices, and other languages can be addressed through translator resources. The SUD prevention program works to match providers and staff to the needs of individuals served. If a qualified member of the participant’s preferred culture is not available, then Benchmark Research and Safety (Idaho’s prevention system manager) works with the provider and the participant to identify a person that is mutually acceptable to deliver the service. The annual Idaho Conference on Alcohol and Drug Dependency offers courses in cultural elements or information on specific cultures.

Transitional Aged Youth: Transitional aged youth diagnosed with a serious emotional disorder who are served through the Children’s Mental Health system (up to age 18) sometimes continue to require mental health services to ensure stability for recovery and resilience. Idaho’s Children’s Mental Health system requirements are different than the Adult Mental Health system requirements, and the transition from one system to another is sometimes challenging.

Evidence Based Practice for Criminal Justice Involved: The Division of Behavioral Health’s priority service population is those who are court ordered for treatment. Behavioral health programs strive to
provide best practice services, and this could be increased with additional training and implementation of evidence based practices that were specifically designed for criminal justice involved individuals with co-occurring behavioral health diagnoses.

**Recovery and Resilience:** One of the identified BHTWG core services is that of peer support. The BHTWG Plan for the Transformation of Idaho’s Behavioral Health System (October 28, 2010) defines this (p. 35) as “Peer support services provide an opportunity for individuals to direct their own recovery and advocacy process and to teach and support each other in the acquisition and exercise of skills needed for management of symptoms and for utilization of natural resources within the community.” As of July 2011, Certified Peer Specialists were working on teams providing mental health services related to Assertive Community Treatment, Projects for Assistance in Transition from Homelessness (PATH), and Critical Time Intervention (ID-HOPE). The Substance Use Disorders program has explored the use of Recovery Mentors to model recovery, focus on wellness and encourage engagement in treatment services. The Division of Behavioral Health would like to continue to promote the use of peers as service providers.

References


Idaho Substance Use Disorder Prevention and Treatment System: A Collaborative Strategy for 2008-2012 (January 2008) prepared by Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) and the Governor’s Transformation Workgroup.


### Table 2 Step 3: Prioritize State Planning Activities

<table>
<thead>
<tr>
<th>Number</th>
<th>State Priority Title</th>
<th>State Priority Detailed Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Priority Area - Mental Health - Adults:</td>
<td>Idaho’s Division of Behavioral Health’s (DBH) Adult Mental Health (AMH) program will provide a comprehensive, consumer-driven, client-centered, recovery-focused continuum of care for adults with a serious mental illness (SMI) or a SMI and a co-occurring substance use disorder (SUD).</td>
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<tr>
<td>2</td>
<td>Priority Area - Mental Health - Children</td>
<td>Idaho will provide a comprehensive, family-driven, recovery-focused, client-centered continuum of care for families and children and youth with a serious emotional disorder (SED) with or without a co-occurring substance use disorder diagnosis.</td>
</tr>
<tr>
<td>3</td>
<td>Priority Area - Substance Abuse Prevention</td>
<td>Idaho will provide evidence-based substance abuse primary prevention services to youth and adults.</td>
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<tr>
<td>4</td>
<td>Priority Area - Substance Abuse Treatment</td>
<td>Idaho will provide evidence-based substance abuse treatment services for youth and adults.</td>
</tr>
<tr>
<td>5</td>
<td>Priority Area - Behavioral Health System Issues</td>
<td>In the next two years, the State Mental Health Planning Council will be replaced by the State Behavioral Health Council, and the Regional Mental Health Advisory Boards and Regional Advisory Councils (SUD) will merge to become Regional Behavioral Health Community Development Boards. The Behavioral Health Transformation Work Group’s proposed Array of Core Services (see Unmet Needs section) will be adopted and implemented for each region. As transformation progresses, Regions will be responsible to develop and implement approved Regional Transformation Plans that address unique needs and resources in each region.</td>
</tr>
<tr>
<td>6</td>
<td>Priority Area - Data and Quality Assurance</td>
<td>The State of Idaho will manage the public behavioral health system with a focus on quality assurance, service outcomes and development of a robust data infrastructure system capable of capturing and extracting data to help guide service system development and implementation.</td>
</tr>
<tr>
<td>7</td>
<td>Priority Area - Substance Abuse Treatment</td>
<td>Idaho will provide substance abuse assessment and treatment services to eligible adults and children with substance use disorder diagnoses who are also intravenous drug users.</td>
</tr>
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<tr>
<td>8</td>
<td>Priority Area - Substance Abuse Treatment - Tuberculosis</td>
<td>Idaho will provide substance abuse assessment and treatment to adults and children who are diagnosed with substance use disorders and who are also diagnosed with tuberculosis.</td>
</tr>
</tbody>
</table>

Footnotes:
### II: Planning Steps

#### Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

<table>
<thead>
<tr>
<th>Priority</th>
<th>Goal</th>
<th>Strategy</th>
<th>Performance Indicator</th>
<th>Description of Collecting and Measuring Changes in Performance Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>a.Strategy: The DBH Family Supports Contract requirements will include community outreach to youth groups to educate and create awareness of mental health issues.</td>
<td>i.Performance Indicator: The DBH Family Supports Contract requirements will include mental health awareness/anti-stigma activities that are advertised in various venues, including the schools and state agencies, throughout the state by June 30,</td>
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</table>

<table>
<thead>
<tr>
<th>Start Year:</th>
<th>2012</th>
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</thead>
<tbody>
<tr>
<td>End Year:</td>
<td>2013</td>
</tr>
</tbody>
</table>
1. Goal: Increase awareness of mental health issues for children and families; decrease stigma and increase early access to information, education and other prevention activities.

2013. b. Strategy: The DBH Family Supports Contract requirements will include providing Idaho youth with emotional and behavioral disturbances with education and support groups throughout the state.

i. Performance Indicator: The DBH Family Supports Contract requirements will include holding a minimum of one (1) support group per region in the state, every other month, for youth ages 8 through 19 with emotional or behavioral disturbances beginning in SFY 2012 and throughout SFY 2013 by 6/30/13.

ii. Performance Indicator: The DBH Family Supports Contract requirements will include holding a minimum of one (1) education group per region in the state, every other month, for youth ages 8 through 19 with emotional or behavioral disturbances.


See CCHH Final Goals in Section IV Dashboard Narrative Goals for specific detail. The Division of Behavioral Health's Central Office will track the number of trainings, number of participants and locations of the contracted Family Supports providers' education and support groups to eligible Idaho youth through the providers' submitted monthly reports.
### Priority Area - Mental Health - Adults:

#### 2. Goal: The state will implement the SSI/SSDI Outreach, Access, and Recovery (SOAR) program in three (3) of the seven (7) Department of Health and Welfare regions.

**a. Strategy:** The State and Community SOAR Leads will educate the regions about SOAR and provide a protocol for the regions to follow as they develop the SOAR process in their communities.

**Performance Indicator:** At least one (1) Region will have appointed a Regional SOAR Lead, collaborated with their local Social Security Administration (SSA) office, and trained at least 25 case managers in their region by June 30, 2012.

**ii. Performance Indicator:** At least two (2) additional regions will have appointed a Regional SOAR Lead, collaborated with their local SSA office, and trained at least 25 case managers in their region by June 30, 2013.

As of December 12, 2011, there was an established SOAR lead in Regions 3, 4 and 5 with at least 25 case managers trained in each region. The target date for this performance indicator was June 30, 2013, but this goal has already been achieved. For detailed report, please see the upload of CCHH Final Goals in Section IV, Dashboard, Narrative Goals.

#### Consumers and family members will have input into the behavioral health service system planning and service implementation.

The DBH service centers will use Evidence-Based Practices that promote consumer choice in all aspects of service delivery.

**DBH will continue to support at least 18 state and/or contract-employed Certified Peer Specialists through state general and federal grant funds through PATH, ID-HOPE, and ACT by June 30, 2013.**

Central Office Division of Behavioral Health will track the number of Certified Peer Specialists employed through regional ACT teams, PATH teams and on the Idaho Home Outreach Program for Empowerment's (ID-HOPE) Critical Time Intervention team through monthly reports from the Office of Consumer and Family Affairs and from the ID-HOPE project.

#### Increase linkages for referral and collaboration between primary care providers and behavioral health care providers.

The DBH will meet with the Department of Public Health and primary care providers to identify collaborative opportunities to meet the needs of Idaho adults.

**DBH will meet with the Idaho Primary Care Association at least two (2) times to identify needs of shared behavioral and primary health care adult clients and collaborative opportunities between programs by June 30, 2012.**

The Division of Behavioral Health will track the number of meetings with the Idaho Primary Care Association and also maintain a dated participant sign-in sheet.
### Priority Area - Mental Health - Adults:

The state will implement the SSI/SSDI Outreach, Access, and Recovery (SOAR) program in three (3) of the seven (7) Department of Health and Welfare regions.

The State and Community SOAR Leads will educate the regions about SOAR and provide a protocol for the regions to follow as they develop the SOAR process in their communities.

At least one (1) Region will have appointed a Regional SOAR Lead, collaborated with their local Social Security Administration (SSA) office, and trained at least 25 Case managers by June 30, 2012.

The Division of Behavioral Health's Central Office will track and maintain a list of Regional SOAR leads and SOAR trainings. Participants in SOAR trainings will sign a dated sign-in sheet.

### Priority Area - Mental Health - Children

**Increase awareness of mental health issues for children and families; decrease stigma and increase early access to information, education and other prevention activities.**

The DBH Family Supports Contract requirements will include providing Idaho youth with emotional and behavioral disturbances with education and support groups throughout the state.

The DBH Family Supports Contract requirements will include holding a minimum of one (1) support group and (1) education group per region in the state, every other month, for youth ages 8 through 19 with emotional or behavioral disturbances beginning in SF.

The DBH Central Office will track the number of trainings, number of participants and locations of the contracted Family Supports provider's education and support groups to eligible Idaho youth through the provider's submitted monthly reports.

### Priority Area - Mental Health - Children

**Increase linkages between primary care providers and behavioral health care providers**

The DBH will meet with the Department of Public Health and primary care providers to identify collaborative opportunities to meet the needs of Idaho children and families.

DBH will meet with the Idaho Primary Care Association at least two (2) times to identify needs of shared behavioral and primary healthcare child and family clients and collaborative opportunities between programs by June 30, 2012.

The DBH Central Office will track the number of meetings held with the Idaho Primary Care Association through dated sign in sheets.

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*The Department of Behavioral Health*

Strategy: The DBH Family Supports Contract will help educate and prepare parents of children and adolescents with...
### Priority Area - Mental Health - Children

(DBH) will implement parent support services for children with emotional and behavioral disturbances and their parents and families. The DBH Family Supports Contract will require implementation of at least 15 parent education/self-advocacy groups throughout the state by June 30, 2013. The DBH Central Office will track the number of trainings, number of participants and locations of the contracted Family Supports provider's parent education and support groups to eligible Idaho parents through the provider's submitted monthly reports.

### Priority Area - Substance Abuse Treatment

Assess appropriate substance abuse level of care, length of stay and access to treatment.

The Management Services Contractor Business Psychology Associates (BPA) performs initial screenings for SA assessment by SUD providers. Screening and referral includes identifying which SAPT population the client meets (e.g., IVDU, pregnant women, PWWC, etc.); determining financial eligibility for state funded services; determining clinical eligibility via the GAIN short screener; referring eligible clients to a DHW SUD provider for a full GAIN. GAIN results are submitted to BPA and they review and either voucher SA services at a clinically appropriate level of care or deny further treatment if the individual does not meet ASAM PPC-2R criteria. The Division of Behavioral Health holds the contract with BPA and provides ongoing oversight and quality assurance to the assessment process.

Continue to monitor BPA assessment process via quarterly BPA contract monitoring.
and either voucher SA services at a clinically appropriate level of care or deny further treatment if the individual does not meet ASAM PPC-2R criteria.

<table>
<thead>
<tr>
<th>Priority Area - Substance Abuse Treatment</th>
<th>Develop a comprehensive plan for Substance Use Disorder (SUD) services to clients whose services are funded through Substance Abuse Prevention and Treatment (SAPT) block grant funds.</th>
<th>Develop treatment criteria for determining Level of Care (LOC), Length of Stay (LOS), and access to treatment.</th>
<th>SUD will use the developed assessment tools to gather baseline data on the existing SUD provider network and on the existing SUD service population by June 30, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Once a written tool has been developed to assess level of care, length of stay and access to treatment, this tool will be used with existing SUD providers. Data will be gathered by the service contractor, Business Psychology Associates, and provided to DBH’s Central Office.</td>
<td></td>
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<tr>
<td></td>
<td>Develop an improved process to provide services to priority population (block grant) IVDU clients that present with the most severity and need of services to ensure efficient utilization of block grant</td>
<td></td>
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</tr>
</tbody>
</table>
Priority Area - Substance Abuse Treatment

Improve screening and identification of IVDU block grant clients.

The Division of Behavioral Health (DBH) and Business Psychology Associates (BPA) will collaborate to develop an improved screening process for potential IVDU clients. DBH’s Substance Use Disorder (SUD) program will draft a more precise definition of IVDU eligibility criteria that BPA will use with clients during the intake process. SUD will train BPA clinical intake staff to use the new IVDU tool to effectively identify IVDU clients with severe need. SUD will draft a precise definition of eligibility criteria for IVDU clients by 6/30/12. SUD will train BPA staff to use this by 6/30/12.

Develop an improved process to provide services to priority population (block grant) IVDU clients that present with the most severity and need of services to ensure efficient utilization of block grant funds. The Division of Behavioral Health (DBH) and Business Psychology Associates (BPA) will collaborate to develop an improved screening process for potential IVDU clients. DBH’s Substance Use Disorder (SUD) program will draft a more precise definition of IVDU eligibility criteria that BPA will use with clients during the intake process. SUD will train BPA clinical intake staff to use the new IVDU tool to effectively identify IVDU clients with severe need.

Priority Area - Substance Abuse Treatment

Improve screening and identification of tuberculosis (TB) clients with SA.

The Division of Behavioral Health will work with the Web Infrastructure Treatment Services (WITS) vendor, FEI, to develop WITS data system capability to track individuals with tuberculosis receiving services through the SSA.

All new SA client information, including whether the person had a TB test in the past & results of TB tests, will be data entered into WITS by 7/1/12. WITS will track TB status for clients with SA services by 6/30/13.

The Division of Behavioral Health’s Central Office will be responsible to negotiate WITS system development with the vendor, FEI, to include the capability to track substance use disorder client information that includes information on client TB testing and results. When the WITs system is implemented for this purpose, Central Office staff will be responsible to track TB data on individuals receiving substance use disorder services through the SSA.
<table>
<thead>
<tr>
<th>Priority Area - Substance Abuse Treatment</th>
<th>Increase the PWWC provider network by at least one additional regional provider</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Psychology Associates (BPA) will collaborate in efforts to identify potential Region 2 PWWC providers. DBH and BPA will work with the identified Region 2 provider to develop a new pregnant women, women with children (PWWC) program in Region 2 in order to expand the existing Idaho PWWC provider network. Identify a potential PWWC Region 2 provider by 6/30/12. Increase the PWWC provider network by at least one additional regional provider in Region 2 by 6/30/13.</td>
</tr>
<tr>
<td></td>
<td>The Division of Behavioral Health (DBH) and Business Psychology Associates (BPA) will collaborate in efforts to identify potential Region 2 PWWC providers. DBH and BPA will work with the identified Region 2 provider to develop a new pregnant women, women with children (PWWC) program in Region 2 in order to expand the existing Idaho PWWC provider network. DBH and BPA will monitor these efforts; once a contract has been finalized, BPA will gather data and DBH will monitor and provide oversight to BPA.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority Area - Substance Abuse Treatment</th>
<th>Maintain available safe and sober housing resources for adults</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Division of Behavioral Health's (DBH) contract with Business Psychology Associates (BPA) to manage SA service providers includes oversight of 12 adult safe and sober housing (SSH) providers with 28 sites in Idaho. Region 6 has only one adult SSH program and Region 5 has no adult SSH program. The DBH will collaborate with BPA and regional resources to identify at least 2 potential adult SSH providers (Region 5 or 6) by 6/30/12. Approve at least one adult SSH provider in R 5 by 6/30/13.</td>
</tr>
<tr>
<td></td>
<td>Identify at least 2 potential adult SSH providers (Region 5 or 6) by 6/30/12. Approve at least one adult SSH provider in R 5 by 6/30/13.</td>
</tr>
<tr>
<td></td>
<td>The Division of Behavioral Health's (DBH) contract with Business Psychology Associates (BPA) to manage SA service providers includes oversight of 12 adult safe and sober housing (SSH) providers with 28 sites in Idaho. Region 6 has only one adult SSH program and Region 5 has no adult SSH program. The DBH will collaborate with BPA and regional resources to identify at least 2 potential providers by 6/30/2012 and approve at least 1 adult SSH provider by 6/30/13 in Region 5.</td>
</tr>
</tbody>
</table>
### Priority Area - Substance Abuse Treatment

**SUD** will begin to move the provider network to a more client-driven system of treatment based on the Recovery Oriented Systems of Care model of service delivery.

**SUD** will develop written tools to evaluate provider service delivery and how well **SUD** services meet client needs, as measured by client responses to satisfaction surveys.

**SUD** will develop a baseline for **SUD** client satisfaction using responses from the client satisfaction tool by June 30, 2013.

Once a written **SUD** client satisfaction tool has been developed, the provider that manages the private provider **SUD** network (i.e., Business Psychology Associates) will ensure that **SUD** clients receive an opportunity to respond to the client satisfaction survey. Business Psychology Associates will gather the data and have it available for **DBH**'s Central Office.

**FACS** staff (including Child Protection Services (CPS) Liaisons) will work with the **DBH** **SUD** program on issues related to clients with open child protection cases and **SUD** diagnoses through at least quarterly meetings.

**FACS** staff, including CPS liaisons and **SUD** program specialists will participate in at least three quarterly meetings to discuss issues related to collaborative service delivery and care coordination to clients with open child protection cases and **SUD** diagnoses.

The **DBH** Central Office will track the number, dates, topics and participants involved in at least quarterly meetings.

### Priority Area - Substance Abuse Treatment

**SUD** will collaborate with **Family and Children's Services (FACS)** on the treatment of shared clients (i.e., clients with open child protection cases and **SUD** diagnoses).

**FACS** staff will work with the **DBH** **SUD** program on issues related to clients with open child protection cases and **SUD** diagnoses through at least quarterly meetings.

**FACS** staff, including CPS liaisons and **SUD** program specialists will participate in at least three quarterly meetings to discuss issues related to collaborative service delivery and care coordination to clients with open child protection cases and **SUD** diagnoses.

The **DBH** Central Office will track the number, dates, topics and participants involved in at least quarterly meetings.

### Priority Area - Behavioral Health System Issues

**By June 30, 2013, and as transformation progresses, regions will be responsible to develop and implement approved Regional Transformation Plans that address unique needs and resources in each region.**

**Develop a Behavioral Health Interagency Cooperative (Cooperative) subcommittee to propose a structure for Regional Behavioral Health Development Boards (Regional Boards), including expectations of Regional Board roles and responsibilities.**

**A written report describing the proposed board structure, roles and responsibilities will be presented to the Cooperative by June 30, 2012.**

The assigned trial test regions will keep minutes of meeting dates, participants and topics discussed, including expectations of Regional Board roles and responsibilities to report back to the Cooperative.
By June 30, 2013, the Regional Mental Health Advisory Boards and Regional Advisory Councils (SUD) will merge to become Regional Behavioral Health Community Development Boards.

All Regional Advisory Councils and Regional Mental Health Boards will sunset by June 30, 2012. Both of these former types of councils/boards will merge to become Regional Behavioral Health Community Development Boards.

The Regional Boards will identify regional needs, plans to develop regional capacity, and plans to provide input into regional behavioral health service provision by June 30, 2013.

Regional Substance Abuse and Mental Health Boards will merge into one Behavioral Health entity by June 30, 2012. Regional Boards will identify written needs and plans by June 30, 2013.

By June 30, 2012, the DBH Quality Assurance unit will collaborate with Regional Mental Health Centers (RMHC) and Private Substance Use Providers (SUD) to develop a written quality improvement plan that defines the following:

• Development of performance indicators that focus on quality of service, appropriateness of services and the pattern of utilization of services.

a. Each indicator must be specific with regard to: what is being measured? how data will be collected? who is...
<table>
<thead>
<tr>
<th>Priority Area - Behavioral Health System Issues</th>
<th>Evolve the role of the Division of Behavioral Health’s (DBH) Quality Assurance unit.</th>
<th>The DBH Quality Assurance Unit will complete a written quality improvement plan for DBH services by June 30, 2012.</th>
<th>The DBH Quality Assurance Unit will have a written DBH quality improvement plan by June 30, 2012.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Collection of meaningful data, how to collect data (e.g. manual tracking forms, computer database, etc) • Reporting of data, how often data will be reported (e.g. quarterly, semi-annually, annually) b. determine types of data to be reported (e.g. chronologically, trends, etc) • How to use the data for improvement across programs • Use of national benchmarking a. how to compare our programs to other programs (e.g. use of Benchmarking study run by the Institute for Behavioral Healthcare)</td>
<td>responsible for the data collection? what is the standard by which success will be measured? how the data will be reported? to whom the reporting will go.</td>
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<tr>
<td>Priority Area - Behavioral Health System Issues</td>
<td>Priority Area - Behavioral Health System Issues</td>
<td>Priority Area - Behavioral Health System Issues</td>
<td>Priority Area - Data and Quality Assurance</td>
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<tr>
<td>Include Tribal leader representation on the State Mental Health Planning Council and in the DBH collaborative meetings.</td>
<td>The DBH will develop a training curriculum for DBH service delivery staff on Gay, Lesbian, Transgender, Bisexual and Questioning cultural awareness.</td>
<td>The Regional DBH service delivery staff will be required to complete this training module on GLTBQ cultural awareness, which will include the need for awareness of the high risk of suicide of this population, by June 30, 2013.</td>
<td>Complete the data warehouse for behavioral health data (SUD, CMH, AMH)</td>
</tr>
<tr>
<td>The State Mental Health Planning Council and the DBH will engage Tribal leadership and identify Tribal behavioral health needs and proposed solutions.</td>
<td>The DBH will develop a cultural awareness training module on GLTBQ cultural awareness that will be added to the DHW on-line Knowledge Learning Center site by June 30, 2012.</td>
<td>The GLBTQ training module will be developed, approved and ready for use on the Department's on-line Knowledge Learning Center (KLC) by June 30, 2012. The number of Department staff completing the training module will be tracked on the on-line KLC site.</td>
<td>DBH will develop a cross division data warehouse that will include the AMH, CMH, and SUD system called WITS, the state hospital system called VistA, and the former CMH and SUD</td>
</tr>
<tr>
<td>The State Mental Health Planning Council and the DBH collaborative meetings will include representation from Tribal leaders from at least two of Idaho’s six federally recognized Tribes by June 30, 2013.</td>
<td></td>
<td>The DBH Central Office SUD Program Specialist will track and participate in activities related to the development of at least two Safe and Sober housing beds for adolescents in each of three regions.</td>
<td>The functional data warehouse will allow cross walking, increased tracking, and interlinking capability between WITS and VistaA for DBH by June 30, 2012.</td>
</tr>
<tr>
<td>The State Mental Health Planning Council and the Division of Behavioral Health will track efforts to invite and engage Tribal leaders of Tribes and share this information with DBH Central Office.</td>
<td></td>
<td></td>
<td>The DBH Central Office Program Specialist will track progress in the development and implementation of the data warehouse that is tasked with cross walking and interlinking multiple systems.</td>
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</table>

The Regional Behavioral Health Councils and the Division of Behavioral Health will make housing and employment resource development a priority for the homeless population. Identify additional sustainable resources for homeless individuals. At least two (2) Safe and Sober Housing program beds for adolescents in each of three regions (Regions 1, 4 and 6) will be established and operational by June 30, 2012.
<table>
<thead>
<tr>
<th>Priority Area - Data and Quality Assurance</th>
<th>DBH will complete the Web Infrastructure Information Technology System (WITS) implementation for Children's Mental Health (CMH) for credible, non-duplicative data collection and report extraction of local, state and federal (e.g., State Outcome Measures) systems.</th>
<th>DBH will direct Focus e-health Innovations Systems, (FEi) the contractor for the WITS data system, to complete modifications and enhancements to the WITS system that is specific to Idaho's needs.</th>
<th>DBH will test FEi produced enhancements and modules. FEi will migrate the final tested product into production by June 30, 2012.</th>
<th>The DBH Central Office Program Specialist will monitor FEi activities, assist with testing and implementation of the FEI modifications and enhancements specific to Idaho's Behavioral Health system needs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area - Data and Quality Assurance</td>
<td>DBH will complete the WITS implementation for SUDS for credible, non-duplicative data collection and report extraction of local, state and federal (e.g., SOMS, TEDS) reporting requirements.</td>
<td>FEi will complete modifications and enhancements to the WITS system that are specific to Idaho's DBH needs.</td>
<td>DBH will establish timeline for implementation by June 30, 2012.</td>
<td>The DBH Central Office Program Specialist will track progress, problem solve challenges and monitor implementation efforts for the FEi modifications to the WITS data infrastructure system.</td>
</tr>
<tr>
<td>Priority Area - Data and Quality Assurance</td>
<td>Establish kiosks at regional behavioral health main offices and at both state hospitals to allow adults with serious mental illnesses and children with emotional and behavioral disorders and their parents to directly input responses to the adult Mental DBH and Information Technology (IT) will collaborate to develop an implementation plan for installing kiosks (including layout and cost analysis) at DBH regional program site locations.</td>
<td>Each of seven (7) DBH regions will have at least one consumer survey kiosk installed and ready to use by June 30, 2012.</td>
<td>The DBH Central Office Program Specialist will participate in plans and monitor implementation activities related to establishing a kiosk at regional DBH service sites by June 30, 2012 and at both state hospitals by June 30, 2013.</td>
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</table>
### Priority Area - Substance Abuse Prevention

<table>
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<tr>
<th>DBH contract with a provider manager to recruit, train, and maintain a provider pool in order to reduce the substance abuse rate in Idaho through prevention services.</th>
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<tr>
<td>The DBH will contract with the substance abuse prevention provider who will be expected to fund community-based entities to deliver substance abuse prevention education to youth in general.</td>
</tr>
<tr>
<td>The DBH contract with the prevention services manager will require that they recruit, train and maintain a community-based prevention provider pool to reduce the substance abuse rate in Idaho through the delivery of prevention services.</td>
</tr>
<tr>
<td>The DBH prevention services management contractor will be required to fund community-based prevention providers to deliver evidence-based parenting education to adults in Idaho.</td>
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<tr>
<td>The DBH contract with the prevention services manager will require at least 25 evidence-based parenting education programs be offered to adults throughout Idaho. A minimum of 2 parenting education programs will be offered per region.</td>
</tr>
<tr>
<td>All data will be collected on the <a href="http://www.preventionidaho.net">www.preventionidaho.net</a> website. The prevention services management contractor will be required by June 1, 2012 to submit a draft parenting education Regional Service Plan to DBH for approval prior to initiation of funding agreement and will be required to submit a final Regional Services Plan on programs funded by Sept. 1, 2012. All funded parenting education programs will be evidence-based.</td>
</tr>
</tbody>
</table>

### Footnotes:

Please see Entire Priorities, Goals, Strategies, and Performance Indicators Document in the Dashboard Section IV. Narrative Plan.
### III: Use of Block Grant Dollars for Block Grant Activities

#### Table 4 CMHS - Services Purchased Using Reimbursement Strategy

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<table>
<thead>
<tr>
<th>Start Year</th>
<th>End Year</th>
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<tbody>
<tr>
<td>2012</td>
<td>2013</td>
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<table>
<thead>
<tr>
<th>Reimbursement Strategy</th>
<th>Services Purchased Using the Strategy</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Encounter based reimbursement</td>
<td>Encounter-based reimbursement—includes fee-for-service and other strategies that pay individuals or organizations a specific amount for a unit of service. Services provided through the Idaho Single State Authority (SSA for substance abuse services) or the Idaho State Mental Health Authority (SMHA) may include participant payment or co-payments according to a sliding scale that is based on income and family size.</td>
<td></td>
</tr>
<tr>
<td>2) Grant/Contract reimbursement</td>
<td>2) Grant/Contract reimbursement—includes annual or periodic payments to individuals or organizations that provide services or system improvements. Substance abuse prevention and treatment both provide contract reimbursements for all prevention activities and all treatment services identified in the block grant strategies. Children’s mental health contracts for parent support services, respite, and public awareness activities. Adult mental health contracts for consumer support, peer specialist training, and peer specialists to work with consumers in the delivery of services. Adult mental health, children’s mental health, and substance abuse combine block grant funds to contract for suicide prevention activities.</td>
<td></td>
</tr>
<tr>
<td>Risk based reimbursement</td>
<td>Risk based reimbursement includes annual or periodic payments to individuals or organizations that provide services or system improvements. The Division of Behavioral Health's Substance Use Disorders (SUD) program contracts with private provider Business Psychology Associates (BPA) to manage the array of private SUD treatment service providers. The administrative reimbursement to BPA is capitated, and the treatment services are reimbursed according to a fee per person per service.</td>
<td></td>
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</table>
Innovative Financing Strategy

Innovative financing strategies—This includes, but is not limited to pay-for-outcomes or payment for an episode of care. As of August 2011, Idaho’s Behavioral Health program did not have existing innovative financing structures for substance use disorder treatment or for adult or children’s mental health services.

Other reimbursement strategy (please describe)

Other reimbursement strategies—States using other reimbursement strategies for services and activities should describe the methodology and the services and activities that are purchased using this methodology. The adult mental health program uses a federally approved cost allocation method based upon a random moment time study to allocate block grant funds for personnel costs. The funds support the activities of staff throughout the state in providing direct services to clients such as crisis intervention, assertive community treatment, assessments, and other direct services. Behavioral health system development is funded through block grant support of costs associated with State Planning Council activities and meetings that are scheduled throughout the year.

Additional funds for behavioral health treatment and services include annual legislative allocations of state general funds and federal grants that support specific services.

Footnotes:
### Table 4 SAPT - Services Purchased Using Reimbursement Strategy

#### III: Use of Block Grant Dollars for Block Grant Activities

**Start Year:**

<table>
<thead>
<tr>
<th>Reimbursement Strategy</th>
<th>Services Purchased Using the Strategy</th>
<th>Other</th>
</tr>
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<tbody>
<tr>
<td>Encounter based reimbursement</td>
<td>Encounter-based reimbursement—includes fee-for-service and other strategies that pay individuals or organizations a specific amount for a unit of service. Services provided through the Idaho Single State Authority (SSA for substance abuse services) or the Idaho State Mental Health Authority (SMHA) may include participant payment or co-payments according to a sliding scale that is based on income and family size.</td>
<td></td>
</tr>
<tr>
<td>Grant/contract reimbursement</td>
<td>2) Grant/Contract reimbursement—includes annual or periodic payments to individuals or organizations that provide services or system improvements. Substance abuse prevention and treatment both provide contract reimbursements for all prevention activities and all treatment services identified in the block grant strategies. Children’s mental health contracts for parent support services, respite, and public awareness activities. Adult mental health contracts for consumer support, peer specialist training, and peer specialists to work with consumers in the delivery of services. Adult mental health, children’s mental health, and substance abuse combine block grant funds to contract for suicide prevention activities.</td>
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</tr>
<tr>
<td>Risk based reimbursement</td>
<td>Risk based reimbursement includes annual or periodic payments to individuals or organizations that provide services or system improvements. The Division of Behavioral Health's Substance Use Disorders (SUD) program contracts with private provider Business Psychology Associates (BPA) to manage the array of private SUD treatment service providers. The administrative reimbursement to BPA is capitated, and the treatment services are reimbursed according to a fee per person per service.</td>
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<tr>
<td>Innovative Financing Strategy</td>
<td>Innovative financing strategies—This includes, but is not limited to pay-for-outcomes or payment for an episode of care. As of August 2011, Idaho's Behavioral Health program did not have existing innovative financing structures for substance use disorder treatment or for adult or children's mental health services.</td>
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<tr>
<td>Other reimbursement strategy (please describe)</td>
<td>Other reimbursement strategies—States using other reimbursement strategies for services and activities should describe the methodology and the services and activities that are purchased using this methodology. The adult mental health program uses a federally approved cost allocation method based upon a random moment time study to allocate block grant funds for personnel costs. The funds support the activities of staff throughout the state in providing direct services to clients such as crisis intervention, assertive community treatment, assessments, and other direct services. Behavioral health system development is funded through block grant support of costs associated with State Planning Council activities and meetings that are scheduled throughout the year. Additional funds for behavioral health treatment and services include annual legislative allocations of state general funds and federal grants that support specific services.</td>
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</tr>
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**Footnotes:**
### III: Use of Block Grant Dollars for Block Grant Activities

**Table 5 CMHS - Projected Expenditures for Treatment and Recovery Supports**

Start Year: 2012  
End Year: 2013

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<thead>
<tr>
<th>Category</th>
<th>Service/Activity Example</th>
<th>Estimated Percent of Funds Distributed</th>
</tr>
</thead>
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| **Healthcare Home/Physical Health** | • General and specialized outpatient medical services  
• Acute Primary Care  
• General Health Screens, Tests and Immunization  
• Comprehensive Care Management  
• Care coordination and health promotion  
• Comprehensive transitional care  
• Individual and Family Support  
• Referral to Community Services | <10% |
| **Engagement Services**          | • Assessment  
• Specialized Evaluation (Psychological and neurological)  
• Services planning (includes crisis planning)  
• Consumer/Family Education  
• Outreach | <10% |
| **Outpatient Services**          | • Individual evidence-based therapies  
• Group therapy  
• Family therapy  
• Multi-family therapy  
• Consultation to Caregivers | 10-25% |
| **Medication Services**          | • Medication management  
• Pharmacotherapy (including MAT)  
• Laboratory services | 10-25% |
| **Community Support (Rehabilitative)** | • Parent/Caregiver Support  
• Skill building (social, daily living, cognitive)  
• Case management  
• Behavior management  
• Supported employment  
• Permanent supported housing  
• Recovery housing  
• Therapeutic mentoring  
• Traditional healing services | 10-25% |
| **Recovery Supports**            | • Peer Support  
• Recovery Support Coaching  
• Recovery Support Center Services  
• Supports for Self Directed Care | <10% |
| **Other Supports (Habilitative)** | • Personal care  
• Homemaker  
• Respite  
• Supported Education  
• Transportation  
• Assisted living services | <10% |
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<tr>
<td></td>
<td>Trained behavioral health interpreters</td>
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<td>Substance abuse intensive outpatient services</td>
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<td>Partial hospitalization</td>
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<td>Clinically Managed Medium Intensity Care</td>
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**Footnotes:**
The filled chart refers to Mental Health (Children and Adults) for both SFY 2012 and SFY 2013. The information for SAPT for SFY 2012 and SFY 2013 are attached in the Attachments section of this document.
### III: Use of Block Grant Dollars for Block Grant Activities

#### Table 5 SAPT - Projected Expenditures for Treatment and Recovery Supports

**Page 30 of the Application Guidance**

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<tr>
<th>Category</th>
<th>Service/Activity Example</th>
<th>Estimated Percent of Funds Distributed</th>
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<td>• Acute Primary Care</td>
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<td>• General Health Screens, Tests and Immunization</td>
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</tr>
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<td>• Individual and Family Support</td>
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<td></td>
<td>• Referral to Community Services</td>
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</tr>
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<td>• Services planning (includes crisis planning)</td>
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<td>• Consumer/Family Education</td>
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</tr>
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<td>• Consultation to Caregivers</td>
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<td>• Pharmacotherapy (including MAT)</td>
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<tr>
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<td>• Supported employment</td>
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</table>
| Intensive Support Services | • Recreational services  
• Interactive Communication Technology Devices  
• Trained behavioral health interpreters  
| Intensive Support Services | • Substance abuse intensive outpatient services  
• Partial hospitalization  
• Assertive community treatment  
• Intensive home based treatment  
• Multi-systemic therapy  
• Intensive case management  
| Out-of-Home Residential Services | • Crisis residential/stabilization  
• Clinically Managed 24-Hour Care  
• Clinically Managed Medium Intensity Care  
• Adult Mental Health Residential  
• Adult Substance Abuse Residential  
• Children's Mental Health Residential Services  
• Youth Substance Abuse Residential Services  
• Therapeutic Foster Care  
| Acute Intensive Services | • Mobile crisis services  
• Medically Monitored Intensive Inpatient  
• Peer based crisis services  
• Urgent care services  
• 23 hour crisis stabilization services  
• 24/7 crisis hotline services  
| Prevention (Including Promotion) | • Screening, Brief Intervention and Referral to Treatment  
• Brief Motivational Interviews  
• Screening and Brief Intervention for Tobacco Cessation  
• Parent Training  
• Facilitated Referrals  
• Relapse Prevention /Wellness Recovery Support  
• Warm line  
| System improvement activities |  
| Other |  

**Footnotes:**
### III: Use of Block Grant Dollars for Block Grant Activities

**Table 6 CMHS - Primary Prevention Planned Expenditures Checklist**

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Start Year: 2012  
End Year: 2013

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>Block Grant FY 2012</th>
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**Footnotes:**
The CMHS program plans to expend funds related to suicide prevention in SFY 2012 and SFY 2013.
### III: Use of Block Grant Dollars for Block Grant Activities

**Table 6 SAPT - Primary Prevention Planned Expenditures Checklist**

Page 36 of the Application Guidance

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<th>Strategy</th>
<th>IOM Target</th>
<th>Block Grant FY 2012</th>
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#### Information Dissemination Total

| Education                     | Universal  | $500,000            | $             | $     | $     | $     |
| Education                     | Selective  | $1,579,784          | $             | $     | $     | $     |
| Education                     | Indicated  | $0                  | $             | $     | $     | $     |
| Education                     | Unspecified| $0                  | $             | $     | $     | $     |

#### Education Total

| Alternatives                  | Universal  | $1,000              | $             | $     | $     | $     |
| Alternatives                  | Selective  | $20,000             | $             | $     | $     | $     |
| Alternatives                  | Indicated  | $0                  | $             | $     | $     | $     |
| Alternatives                  | Unspecified| $0                  | $             | $     | $     | $     |

#### Alternatives Total

| Problem Identification and Referral | Universal | $                           | $             | $     | $     | $     |
| Problem Identification and Referral | Selective | $75,000                     | $             | $     | $     | $     |
| Problem Identification and Referral | Indicated | $                           | $             | $     | $     | $     |
| Problem Identification and Referral | Unspecified| $0                       | $             | $     | $     | $     |

#### Problem Identification and Referral Total

|                        |             | $75,000 | $ | $ | $ | $ |
### Community-Based Process

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### Section 1926 Tobacco

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<tr>
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<td><strong>Total</strong></td>
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### Other

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### Footnotes:

The above Substance Abuse Prevention relates to one year; it is projected to be the same for SFY 2012 and SFY 2013.

The above projection includes the following:
- Information Dissemination (Universal; Activities 1, 3, 7) includes RADAR and media campaign
- Education 1) Universal; Activities 1, 2, 4; Selective; Activities 2, 4, 5; Indicated; Activity 4 - community based providers
- Alternatives (Selective; Activities 2, 4) - community based providers
- Problem Identification (Indicated; Activity 2) - community based providers
- Community Based Process (Universal, Activities 1, 2, 3, 5) - community coalitions
- Environmental Strategies (Universal; Activity 2) - community coalitions
- Section 1926 Tobacco (Selective) - tobacco retailers
III: Use of Block Grant Dollars for Block Grant Activities

Table 7 CMHS - Projected State Agency Expenditure Report
Page 38 of the Application Guidance

Start Year: 2012
End Year: 2013

Date of State Expenditure Period From: 10/01/2011       Date of State Expenditure Period To: 09/30/2013

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Block Grant</th>
<th>B. Medicaid (Federal, State, and Local)</th>
<th>C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>D. State Funds</th>
<th>E. Local Funds (excluding local Medicaid)</th>
<th>F. Other</th>
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<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
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<td>$[ ]</td>
<td>$[ ]</td>
<td>$[ ]</td>
<td>$[ ]</td>
<td>$[ ]</td>
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<tr>
<td>2. Primary Prevention</td>
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<td>$0</td>
<td>$0</td>
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<td>3. Tuberculosis Services</td>
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<td>$[ ]</td>
<td>$[ ]</td>
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<tr>
<td>4. HIV Early Intervention Services</td>
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<td>$[ ]</td>
<td>$[ ]</td>
<td>$[ ]</td>
<td>$[ ]</td>
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<tr>
<td>5. State Hospital</td>
<td>$[ ]</td>
<td>$8,387,800</td>
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<td></td>
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<td>7. Ambulatory/Community Non-24 Hour Care</td>
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<td>8. Administration (Excluding Program and Provider Level)</td>
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<td>11. Total</td>
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<td>$9,349,600</td>
<td>$8,612,800</td>
<td>$83,056,800</td>
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<td>$6,482,200</td>
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</table>

Footnotes:

CMHS Projected Expenditures Table is based on the following:
24 Month Period projections include State Fiscal Year 2012 (7/1/11-6/30/12) and State Fiscal Year 2013 (7/1/12-6/30/13).
All expenditures that support community based care are included in the Ambulatory/Community Non-24 Hour Care category.
Table 7 SA - Projected State Agency Expenditure Report
Page 38 of the Application Guidance

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Block Grant</th>
<th>B. Medicaid (Federal, State, and Local)</th>
<th>C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>D. State Funds (excluding local Medicaid)</th>
<th>E. Local Funds</th>
<th>F. Other</th>
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<tr>
<td>3. Tuberculosis Services</td>
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<td></td>
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<tr>
<td>4. HIV Early Intervention Services</td>
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<td>5. State Hospital</td>
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<td>6. Other 24 Hour Care</td>
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<td>7. Ambulatory/Community Non-24 Hour Care</td>
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<td>8. Administration (Excluding Program and Provider Level)</td>
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<tr>
<td>10. Subtotal (Rows 5, 6, 7, and 8)</td>
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<td>$633,200</td>
<td>$18,200</td>
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<tr>
<td>11. Total</td>
<td>$6,855,073</td>
<td>$5,062,600</td>
<td>$5,891,200</td>
<td>$6,633,200</td>
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Footnotes:

SAPT Projected Expenditures Table is based on the following:
24 Month Period projections include State Fiscal Year 2012 (7/1/11-6/30/12) and State Fiscal Year 2013 (7/1/12-6/30/13).
All expenditures that support community based care are included in the Ambulatory/Community Non-24 Hour Care category.
Other than the state funds used for prevention of minor's access to tobacco activities, there are no supplemental for prevention.
### III: Use of Block Grant Dollars for Block Grant Activities

#### Table 8 Resource Development Planned Expenditure Checklist

Page 40 of the Application Guidance

| Start Year: 2012 | End Year: 2013 |

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<thead>
<tr>
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#### Footnotes:

The Table 8 data reflects only one year of CMHS and SAPT expenditures. This projection is estimated to be the same for SFY 2012 and SFY 2013.

CMHS portion reflects the following:
- Planning, Coordination, Needs Assessment reflects $153,000 for Peer Specialist/Family Empowerment contract.
- Quality Assurance reflects $25,000 for quality improvement efforts.
- Program Development reflects $20,000 for Training, and $269,267 for Family Run Organization service contract.
- The CMHS chart does not include $1,205,898 for Adult Mental Health direct service provision.
- The CMHS chart does not include $20,000 to support the Statewide Planning Council.

The above does not reflect $90,843 for 5% Administrative Costs.

The SAPT portion does not reflect the following:
- 5% Administrative Costs at $343,492.
- Direct SUD services at $4,938,142 reflect client intake and service coordination (e.g., demographics, financial requirements, TEDS, NOMS, clinical eligibility), level of care determination, continued stay review and administrative discharges.
IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services
Page 41 of the Application Guidance

Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:
Activities that Support Individuals in Directing Services

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual’s needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following: 1) Either summarize your State’s policies on participant-directed services or attach a copy to the Block Grant application(s). 2) What services for individuals and their support systems are self-directed? 3) What participant-directed options do you have in your State? 4) What percentage of individuals funded through the SMHA or SSA self direct their care? 5) What supports does your State offer to assist individuals to self direct their care?

Idaho Policies on Participant Directed Services

There are several existing sources that focus on participant directed services and some policies that are being developed for the Division of Behavioral Health that will provide further detail on this. The Children’s Mental Health Practice Manual (see http://infonetdhw/LinkClick.aspx?fileticket=xzHfEo3-M9Q%3d&tabid=514&mid=2855), Chapter 1, describes family centered practice and its role in service delivery. Foundational aspects include recognition that families are experts capable of identifying their own goals and solutions, and these can be implemented with support from community partners. Tab 9 of this document (p. 131) describes core values that include “The system of care should be child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided.”

The Quality Assurance Policy (see attached) includes a description of stakeholder review systems that provide input and feedback into the mental health system. Stakeholders include, and are not limited to, the State Planning Council on Mental Health, regional mental health boards, the Office of Consumer and Family Affairs (OCFA), consumers, family members, state and local correction agencies, courts, Vocational Rehabilitation, Education. Quality assurance reviews may include interviews with family members, treatment providers or other involved parties (see Continuous Quality Improvement Policy, attached).

Self-Directed Services for Individuals and Their Support Systems

The Web Infrastructure for Treatment Services (WITS) system includes a treatment planning section. The treatment plan section was written to encourage use of the client’s own words and goals (e.g., “My current situation is…” “My overall recovery goal is…”). The WITS discharge includes “My Continuing Care Plan,” which is influenced by Mary Ellen Copeland’s Wellness Recovery Action Plan (WRAP).

The Substance Use Disorders (SUDS) program contracts with Business Psychology Associates (BPA) to manage the array of community substance use providers, provide training, pre-authorize services and collect and report SUD data to the Division. Training to providers includes training on the “Stages of Change” model, with an emphasis on Motivational Interviewing. Motivational interviewing is designed to meet the client where they are in their personal stage of recovery, and provide supports to meet the
client’s recovery goals. During the initial screening, BPA affirms the client’s agreement with the screened level of care and offers the client options of providers that offer that level of care.

The Department of Health and Welfare provides web training through the Knowledge Learning Center (KLC). The SAMHSA Tip 42: Substance Abuse Treatment for Persons with Co-occurring Disorders course provides 20 CEUs, with an on-line quiz at the end of each module. Division staff have access to this training and are encouraged to complete it if they are working with individuals diagnosed with co-occurring mental health and substance use disorder diagnoses.

**Participant Directed Options**

The State of Idaho’s mental health service delivery system values and supports participant directed options. Mental Health Block Grant funds help to support a contract with the Mountain States Group’s Office of Consumer and Family Affairs (OCAFA). The OCAFA established a 40 hour Certified Peer Specialist training program in SFY 2009, based on the Appalachian Group’s model. All Certified Peer Specialists are also required to complete an additional week of Wellness Recovery Action Plan (WRAP) training (based on Mary Ellen Copeland’s work). The OCAFA supervises paid placements of Certified Peer Specialists at regional Division of Behavioral Health locations. Certified Peer Specialists model recovery and resilience through their work on Regional Mental Health Assertive Community Treatment (ACT) teams and Projects for Assistance in Transition from Homelessness (PATH) teams. Additional Certified Peer Specialists were hired by Pioneer Health to provide Critical Time Intervention (CTI) services through the CMHS Transformation grant funded Idaho Home Outreach Program for Empowerment (ID-HOPE). The ID-HOPE project began delivering services in pilot project regions 3 and 4 in March 2011.

Idaho also benefits from National Alliance for the Mentally Ill (NAMI) groups. These groups provide family education, support and advocacy. The Boise NAMI group sponsors an annual NAMI walk as both an awareness event and as a fundraiser for their education and advocacy efforts. Additionally, some groups offer Family to Family education groups.

The Children’s Mental Health program has a contract with the Federation of Families (July 2011) that uses some block grant funds to provide education, training and advocacy to families with children with serious emotional disorders. The Federation of Families collaborated with other agencies to develop and offer a Recovery conference in Boise, Idaho in June 2011. The OCAFA and the ID-HOPE programs provided panel discussions of the services they provide and the ways that they are able to model recovery and resilience.

**Percentage of SMHA and SSA Participants Directing Their Own Care**

It is difficult to gauge the percentage of SMHA and SSA participants that direct their own care. Division staff are encouraged to focus on person centered planning for all service recipients. Treatment modalities are designed for consumer and family involvement.

For clients receiving SUD treatment services, BPA offers choice in providers. Some eligible SUD clients are referred through the corrections and/or court system. In SFY 2011, some corrections referred individuals indicated that their probation officer had asked them to see a specific provider. During the SFY 2011 legislative session, decisions were made to re-allocate some treatment funds that were previously allocated to the Division were allocated instead to Adult Corrections, Juvenile Corrections and the courts. Fund re-allocation was designed to give those partnering agencies control of how they could best determine treatment services for their specific populations.
One of the challenges in ensuring self-directed care is that many of the service recipients have been court-ordered to treatment. Under those conditions, participants may not have voluntarily chosen to receive Division of Behavioral Health Care services. Once they have been enrolled, efforts are made to encourage increased self-direction and planning.

**Idaho Supports to Assist Individuals to Self-Direct Their Own Care**

The Idaho Division of Behavioral Health designed the WITS system to encourage clinicians to focus on person-centered treatment planning. Wellness recovery is available through the OCAFA WRAP trainings, and these are also offered in some of the regional programs to center clients. The discharge process for the Adult Mental Health program requires completion of “My Continuing Care Plan” for recovery. The Children’s Mental Health program is designed with family involvement as a core principle. Motivational interviewing, stages of change and the SAMHSA Tip 42 training models provide treatment training to providers that encourage client involvement in treatment planning and decision making. The regional boards and the statewide board (both in the current and the planned compositions) focus on consumer and family involvement in system planning, implementation and evaluation.
Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State’s IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State’s current efforts to assist providers with developing and using Electronic Health Records.
E. Data and Information Technology

Unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds.

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provides information on one or more of the following:

  The Division of Behavioral Health’s Adult Mental Health (AMH), Children’s Mental Health (CMH), and Substance Use Disorders (SUD) programs provide information on publicly funded AMH, CMH and SUD services. The AMH program is using WITS for data collection needs. The CMH program is transitioning from use of FOCUS to use of WITS. The SUD program contracts with Behavior Psychology Associates (BPA) to collect data pertaining to substance use disorders services. Business Psychology Associates uses the eCura ProviderConnect system. This data is submitted to the Division of Behavioral Health. Once adaptations for substance use disorder services are completed and implemented for the Division of Behavioral Health’s Web Infrastructure for Treatment Services (WITS) system, this information will be collected in WITS. The State Hospital systems (i.e., State Hospital North (SHN) and State Hospital South (SHS)) provide data on Idaho citizens psychiatrically hospitalized at SHN and SHS using the VistA system. Data on Division of Behavioral Health trainings and SUD prevention is tracked through EXCEL spreadsheets through the Division’s Central Office location.

  - Provider characteristics
    The Division of Behavioral Health contracts with vendor FEI to develop, train, implement and host the WITS system. The WITS system is capable of tracking service provider locations and other characteristics. This system has been implemented for Adult Mental Health (AMH) services; data element definitions for the National Outcome Measures were built in WITS using the Client Level Reporting Project data element definitions. The Division of Behavioral Health and FEI are in the process of building data elements to collect and report on required data for SUD and for Children’s Mental Health (CMH) program services. The two state hospitals, State Hospital North (SHN) and State Hospital South (SHS) use the VistA data infrastructure system. The Division of Behavioral Health is working on a data warehouse that will allow client data from the VistA system to be crosswalked to the WITS system so that client services can be tracked. The SUD program relies on provider characteristic data provided through BPA, but once WITS is completed for SUD, this data will be collected through WITS.

  - Client enrollment, demographics, and characteristics
    The AMH and CMH programs are able to capture client level data, including client demographics, characteristics, enrollments (admission/discharge), assessments, & non-Medicaid services (type, provider, duration, amount) through the WITS system. The SUD program relies on client characteristic data provided through BPA, but once WITS is completed for SUD, this data will be collected through WITS.

  - Admission, assessment, and discharge
    The SUD program uses the Global Appraisal of Individual Need (GAIN) tool for assessments. The data collected from the GAIN is maintained by Chestnut Health Services and not accessible through BPA’s eCura data collection system or through the Division of Behavioral Health’s WITS system. Starting in October 2011, Chestnut will submit monthly and quarterly GAINS aggregate data to the Division of Behavioral Health and to individual providers in the SUD provider network.

  - Services provided, including type, amount, and individual service provider
For AMH and CMH programs, service and service provider information is collected through WITS. With respect to SUD, services, types of services, service amounts and service provider information may be requested from BPA. Once WITS is completed for SUD, this information will be collected through WITS.

- **Prescription drug utilization**
The Division of Behavioral Health uses WITS, VistA, Drug Assistant Software, LOCUS/CALOCUS and CAFAS/PECAFAS to track prescription drug utilization for AMH and CMH. Data pertaining to prescription drug utilization for SUD is not available.

- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
    Division of Behavioral Health SUD/AMH/CMH providers (excluding Medicaid) do not have to obtain national provider identifiers. The WITS system is capable of collecting and reporting national provider identifiers. In addition, the WITS screen shot below identifies other pertinent data that is collected:

![WITS Screen Shot](image)

- Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  Please see the WITS screen shot above.

- Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
The WITS system uses a unique client identifier based on a numerical value assigned to the letters of the first and last name, the date of birth (DOB), and the Social Security Number (SSN). The identifiers cannot be duplicated in any given provider agency. In theory, extracting information for unduplicated clients can be pulled by identifier. Realistically, there could be the possibility of the same client being assigned multiple identifiers in WITS if the information used to assign the identifier is entered differently (e.g., a client DOB entered differently in Region 1 than in Region 2 will result in two different identifiers). For Division of Behavioral Health purposes, reports are built to look at the identifier and other unidentifiable information. The WITS system does have the ability to aggregate services rendered to the client.

- Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?

The screen shot (below) of the encounter note in WITS captures the following:

![Encounter Note Screen Shot](image)

Medicaid client level encounter/claims service and provider data were not available for CMH in July 2011. Non-billed service data will be available one year after CMH implements WITS in July 1, 2011.

- Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?

While the WITS system is now using the ICD-9 with up to date CPT/HCPCS codes, there are plans to load ICD-10 if funding can be identified for Behavioral Health programs. The CPT/HCPCS codes are editable code tables. These may be updated as new codes and changes are released each year, as long as funding is available to support those costs.
As applicable, please answer the following:

○ Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?

As of July 2011, provider and client identifiers in the WITS, VistA and BPA systems did not allow for linkage with Medicaid provider identifiers. Client identification numbers through WITS are generated based on name and birth date. While the WITS system does attempt to capture a consumer’s Medicaid number, this is not required or always known when a client profile is created or updated. The Division of Behavioral Health is working on a data warehouse in an effort to allow linkage to other systems.

○ Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?

As of July 2011, WITS was not linked with Medicaid behavioral health data. The WITS system does capture the client's insurance type. If the client is identified in WITS as having Medicaid, some reports could be extracted (e.g., service utilization).

○ Does your State’s IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?

The Division of Behavioral Health works with the WITS vendor, FEI, to address issues related to system interoperability. FEI is working on a Meaningful Use certification. The Department of Health and Welfare’s Idaho Health Data Exchange committee includes representation from Medicaid (see http://www.idahohde.org/news/idmedImages040109.html).

○ Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?

Idaho received a section 3013 grant for development of a health information exchange under the HITECH Act; the Idaho Health Data Exchange (IHDE) is the state designated entity for recipient of the grant funding. IHDE is a statewide health information organization and has been operational as an HIE since 2009. IHDE includes a clinical data repository. Clinical staff at State Hospital North and State Hospital South can access the repository for clinical information, such as lab results, for patients they are treating. Mental health and substance abuse data are not currently included in the exchange. IHDE’s Security and Privacy Committee is reviewing the SAMHSA FAQs related to substance abuse confidentiality and health information exchange to determine IHDE’s next steps in this regard. IHDE, at the invitation of the behavioral health bureau chief, sent a staff member to the SAMHSA-Sponsored 2011 Health Information Technology Regional Forum to learn more about the issues and opportunities in this area.

○ Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

While Medicaid is engaged in efforts to improve their IT system, the Division of Behavioral Health is not routinely included in those plans or efforts.
In addition to the questions above, please provide any information regarding your State’s current efforts to assist providers with developing and using Electronic Health Records. All public AMH and CMH providers will be using WITS in SFY 2012. The AMH system was implemented in October 2001 and the CMH system is scheduled for implementation in July 2011. Implementation for the State’s SUD contracted network of substance use disorder providers is scheduled before the end of SFY 2012.
IV: Narrative Plan

F. Quality Improvement Reporting
Page 43 of the Application Guidance

Narrative Question:
SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:
Quality Improvement Reporting

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that these services, to the extent possible, reflect their evidence of effectiveness. The State’s CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State’s current CQI plan.

The State of Idaho’s Division of Behavioral Health includes a Quality Assurance unit. The Quality Assurance unit is designed to ensure Continuous Quality Improvement (CQI) in administrative operations and service delivery. The Quality Assurance (QA) Policy (see attached) describes expectations for quality assurance that include 1) quality management team structure and responsibilities, 2) QA/CQI case reviews, 3) corrective action, 4) performance improvement and 5) stakeholder review systems.

Regional Quality Management Teams are expected to meet at least quarterly. During these meetings, the teams will track programmatic improvements, including customer satisfaction results; review complaints and adverse outcomes/incidents and develop resolution plans; and review data for opportunities to improve and to implement decision making strategies in response to identified trends.

The Continuous Quality Improvement (CQI) Policy (see attached) “…provides direction on the review of Adult Mental Health and Children’s Mental Health cases to ensure compliance with Department of Health and Welfare and Division of Behavioral Health rules, policies and best practice standards.”

The Division of Behavioral Health works with the Center for the Application of Substance Abuse Technologies (CASAT; go to http://casat.unr.edu/ for additional information) at the University of Nevada for treatment and recovery support service provider certification. CASAT conducts site visits at each provider location. If the provider does not meet Idaho code standards, CASA submits a Corrective Action Plan to the provider and to the Division. The provider submits a written response to each element of the Corrective Action Plan to the Division of Behavioral Health. If the provider submission meets standards, then the Division approves and signs off on the certification.

The Division of Behavioral Health contracts with Business Psychology Associates (BPA) to manage the array of private substance abuse providers. One aspect of this is ensuring the delivery of quality services. The BPA Clinical Quality Checklist and Clinical Chart Audit tools are attached.
IV: Narrative Plan

G. Consultation With Tribes
Page 43 of the Application Guidance

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:
Consultation with Tribes

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications. Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Idaho has six different federally recognized tribes. These are the Shoshone Bannock, the Northwest Band of the Shoshone, the Nez Perce, the Coeur d’Alene, the Kootenai and the Duck Valley (Shoshone Paiute) six tribes.

The Division of Medicaid has quarterly engagement with the Tribes which includes policy and process consultation. Quarterly, statewide meeting between Medicaid and the Idaho Tribes focuses on sharing planned Medicaid program changes and consulting with the Tribes about potential impacts of these changes on their programs and members medical care. A Medicaid SharePoint site provides advance notice of planned program changes, and this is available to the Tribes.

The Medicaid/Medicare meeting at Nimiipuu Clinic was initiated by Social Security Public Relations. The Social Security person initiating this meeting found that some Tribal questions relate to Medicaid, some to Medicare and some to Social Security. This office outreach to Tribes tends to be informal and usually includes invitations to local Division of Welfare staff as another resource to answer questions regarding Medicaid eligibility. These are not forums for compliance with Consultation requirements within the Department. These are rather select and small events specifically geared to clinic patient advocate type staff.

The Division of Welfare also has quarterly meetings surrounding Temporary Assistance for Needy Families (TANF) issues for basic welfare programs. The Division of Family and Children Services (FACS) has quarterly engagement with the Tribes through the Indian Child Welfare Advisory Council (ICWAC). The Division of Health has a Cultural Liaison who attends these functions along with the Legislative Council on Indian Affairs. It should be noted that each of the formal Divisional Tribal engagements described above involve different Tribal leadership and programs. For example, Medicaid involves Tribal Clinic managers, Welfare meets with TANF Tribal leaders, and FACS meets with Tribal Social Service leaders.

As of July 2011, the Division of Behavioral Health had no formal relationship with the Tribal leaders. The Division of Behavioral Health SUD provider network includes the tribally owned Benewah Medical and Wellness Center in northern Idaho (Plummer), but interaction with the Division is limited to the facility renewal process. Behavioral Health efforts to engage the Tribal leaders would likely evolve into meetings between the Division of Behavioral Health and Tribal Mental Health and Substance Abuse programs.
G. Consultation with the Tribes - Sandra Adrovet Response

After the Idaho Behavioral Health Assessment and Plan was submitted, a new initiative was developed. The final verbiage on legislation is being drafted which will enable the DBH to effectively consult and collaborate with communities and Tribes located in Idaho. The draft legislation will create Regional Behavioral Health Boards to support and coordinate Behavioral Health services at the community level. It is proposed that a Tribal Leader will be invited to participate in the Board in each region where a Tribe is located. Examples of other proposed members of the Regional Behavioral Health Boards are county commissioners, recovering individuals and family members, DBH regional staff, private substance abuse and mental health professionals, education professionals, adult and juvenile corrections staff, and other health practitioners. The Board’s responsibilities will include assessment of community services and resources, identification of service gaps, coordination of services, facilitation of information sharing and service enhancement development. The Boards may also collaborate on new projects/services for their regions and seek supplementary funding. The Regional Behavioral Health Boards will meet on a regular basis to address issues related to the substance use disorders treatment system, the substance abuse prevention system and the mental health treatment and prevention system. All of these activities will enable DBH to formally consult with Tribal Leadership to develop a collaborative system of care for Behavioral Health prevention, treatment and recovery.
IV: Narrative Plan

H. Service Management Strategies
Page 44 of the Application Guidance

Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:
Service Management Strategies
SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers. In the space below, please describe: 1) The processes that your State will employ over the next planning period to identify trends in over/underutilization of SAPTBG or MHSBG funded services, 2) The strategies that your State will deploy to address these utilization issues, 3) The intended results of your State’s utilization management strategies, 4) The resources needed to implement utilization management strategies and 5) The proposed timeframes for implementing these strategies.

SFY 2012-2013 Processes to Identify Over/Underutilization Trends of SAPT/MHBG Funded Services
The Division of Behavioral Health’s Quality Assurance Unit was established in SFY 2011 to ensure appropriate regional Community Mental Health Center (CMHC) service utilization and quality of care. Central Office provides oversight of these activities. State Hospital North and State Hospital South are responsible to track and manage state hospital utilization and quality of care.

As of July 2011, Medicaid was pursuing a contract with a managed care organization (MCO) with a target implementation date of 7/1/12 for the administration of mental health benefits. A 1915b waiver will be in place as the funding authority to support the MCO contract. Qualis signed a three year contract renewal with Medicaid in June 2011 to provide case management and utilization management services.

Utilization Strategies, Intended Results, Resources and Time Frames
The Quality Assurance Unit is responsible to implement the Division of Behavioral Health’s CQI activities. As of July 2011, the central office unit was composed of a mental health clinician/program specialist and program manager. Another program specialist will be hired in SFY 2012 to focus on implementing quality assurance efforts related to the Substance Use Disorder program.

In January of 2011, the Division of Behavioral Health implemented two policies to address the quality and effectiveness of services provided to children and adults. The first policy entitled Quality Assurance, established a Quality Management Team in each of the seven regions in the state. The Quality Management (QM) Team is required to meet at least quarterly to review cases, complaints and customer satisfaction survey results. The QM team also reviews data to assess trends and practice implications. The second policy, Continuous Quality Improvement (CQI), established a process for the Quality Assurance Unit to conduct a random sample review of mental health case files in each region, using an established CQI instrument. The CQI instrument is designed to assess compliance with Idaho rules, policies, and best practice standards. A minimum of five (5) Adult Mental Health and five (5) Children’s Mental Health cases are reviewed twice a year in each region. Regions are required to establish a corrective action plan to address each identified area of noncompliance.

The Division contracts with the Management Services Contractor, Business Psychology Associates (BPA), to manage the SUD treatment service delivery through a network of Department approved treatment providers. BPA also provides SUD care management utilization review. Care Management responsibilities include use of a statewide 1-800 number for eligibility screenings, to make an initial ASAM PPC-2R level of care determination and to prior authorize units of service. The Division’s SUD program also oversees substance abuse prevention for those who do not require treatment for substance abuse. The Division contracts with Benchmark Research and Safety (BRS), the Prevention Technical Assistance and Support Contractor (PTASC), to manage an on-line system for generating program specific prevention data for the National Outcome Measures (NOMS).

The Division of Behavioral Health’s Adult Mental Health (AMH) and Children’s Mental Health programs are also responsible to assess level of care. The AMH program uses the LOCUS tool and the CMH program uses the CALOCUS tool to assess acuity and level of care service needs.
The two state psychiatric hospitals (i.e., State Hospital North and State Hospital South) operate utilization reviews of the hospital provided service system. The hospitals have their own set of policies and procedures for care utilization reviews. Data is tracked and shared during Division Leadership Team meetings.

The Division of Behavioral Health follows a Utilization Review Plan designed to ensure appropriate service utilization at the two state psychiatric hospitals, the regional Division of Behavioral Health centers (i.e., adult mental health and children’s mental health) and the state funded Substance Use Disorder (SUD) provider sites. The Division’s Utilization Review Plan is designed to ensure care is provided at a level appropriate to the client’s treatment needs. The Plan includes use of a Utilization Review Subcommittee that meets quarterly to 1) review all stages of admissions (e.g., medical necessity for admission, over/under-utilization of ancillary services, delays in services, quality of care indicators, adequacy of clinical/medical record documentation, length of stay, and discharge timeliness), 2) report review findings and recommendations to the Division of Behavioral Health’s Leadership team, and 3) analyze issues, problems, or individual cases identified through utilization review activities, make recommendations for resolution, and/or recommend referral to other resources. The Division also conducts a quarterly review of 1) system eligibility and admissions, 2) service utilization, and 3) effectiveness and appropriateness of ancillary and support services, quality of care and discharge planning.

Results of Quality Assurance assessment of trends and utilization review are used by the Division of Behavioral Health’s Leadership Team to identify service delivery effectiveness. This information allows identification of services that work well and services that do not appear to be as effective. As efficient and cost effective services are identified that promote recovery and resilience, funds and services may be directed to those areas.
Substance Abuse Prevention Services Management Strategies

1. Over/Underutilization Management
Idaho’s Substance Abuse Prevention Services are managed at two levels to support a comprehensive system to ensure prevention services are offered in areas of greatest need. At the state level, a review of existing resources is conducted to determine need for continued funding of programs and activities available to all state residents, such as the RADAR Center, the Idaho Minor in Prevention College Support and training resources for prevention providers. This enables Idaho to support needed programs while eliminating duplication of efforts.

At the community level, Idaho uses a 3-step approach to management of over/underutilization. The first step is to conduct a county level needs assessment. This assessment is done by research professionals to limit bias. The second step is for community-based prevention providers to apply for funding to deliver prevention services. As a part of their application, providers must conduct a community resource assessment to ensure they are proposing to serve an unmet need. They are required to use evidence-based programs with sufficient dosage to impact the identified risk factor(s). The third step focuses on the review of community-based providers’ applications. This step is the responsibility of the Prevention Services Contractor’s regional staff. Because the regional staff members are located throughout the state, they are able to review applications to verify that the proposed services will meet a need that cannot be covered by other resources. They also review the proposed program to determine that there is sufficient documentation to validate the program is appropriate for the prioritized population, and the dosage is sufficient to impact the identified risk factor(s).

Finally, at both the state and local level, all services are purchased via fixed-amount contracts. Under this system a specified number of services are delivered at the rate established in the contract up to the total of the contract. No over expenditures are allowed or paid. This ensures all services are available throughout the term of the contract and that no provider is allowed to over spend at the cost of another provider or community.

2. Utilization Issues Strategies
Idaho will continue the 3-step approach to services funding to ensure that participants served receive an evidence-based program, appropriate for the population with sufficient dosage to support behavioral or values development or change. Because Substance Abuse Prevention services are funded via contract, all invoices received by the state are reviewed to ensure they comply with the terms of the contract. Each quarter a budget review is held to evaluate compliance with the established budget. Any contractors who are under or over budget are notified of the concern and required to submit a correction action plan. For the following quarters, only the sum remaining in the contract will be available to invoice.

3. Intended Results
The Substance Abuse Prevention budget is very limited. Idaho is a large state with many small isolated communities, failure to manage the costs of prevention services would result in the loss of sorely needed services. The activities identified in Steps #1 and #2 are designed first to ensure that individuals receive evidence-based programming to address identified risk factors and result in behavior or values development or improvement. It is essential that all services are delivered
within the budget set in the contract in order to ensure that all service costs will be covered within the state fiscal year. The intended results of the utilization strategy above are to ensure that funding for services is available as contracted to serve the populations most in need.

4. Resources Needed
Idaho’s process for evaluating duplication of effort prior to contracting, the use of fixed-fee contracts and the quarterly budget review system ensures that prevention services are delivered to those most in need and that the prevention funds are managed to ensure there is no over utilization. Because the current system is working, no additional resources will be needed.

5. Timeframe
All strategies are currently in place and will remain so throughout the duration of the grant period.
IV: Narrative Plan

I. State Dashboards (Table 10)

Page 45 of the Application Guidance

Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

<p>| Plan Year: 2012 |
|------------------|------------------|------------------|
| Priority Area  | Performance Indicator | Selected |
| Mental Health - Adults: | See strategy above for performance indicators for outreach, education and support by 6/30/13. |  |
| Mental Health - Adults: | Performance Indicator: At least one (1) Region will have appointed a Regional SOAR Lead, collaborated with their local Social Security Administration (SSA) office, and trained at least 25 Case managers by June 30, 2012. |  |
| Mental Health - Adults: | DBH will continue to support at least 18 state and/or contract-employed Certified Peer Specialists through state general and federal grant funds through PATH, ID-HOPE, and ACT by June 30, 2013. | b |
| Mental Health - Adults: | DBH will meet with the Idaho Primary Care Association at least two (2) times to identify needs of shared behavioral and primary health care adult clients and collaborative opportunities between programs by June 30, 2012. | e |
| Mental Health - Adults: | At least one (1) Region will have appointed a Regional SOAR Lead, collaborated with their local Social Security Administration (SSA) office, and trained at least 25 Case managers by June 30, 2012. | e |
| Mental Health - Children | The DBH Family Supports Contract requirements will include holding a minimum of one (1) support group and (1) education group per region in the state, every other month, for youth ages 8 through 19 with emotional or behavioral disturbances beginning in SF | e |
| Mental Health - Children | DBH will meet with the Idaho Primary Care Association at least two (2) times to identify needs of shared behavioral and primary healthcare child and family clients and collaborative opportunities between programs by June 30, 2012. | e |
| Mental Health - Children | The DBH Family Supports Contract will require implementation of at least 15 parent education/self-advocacy groups throughout the state by June 30, 2013. | b |
| Substance Abuse Treatment | Continue to monitor BPA assessment process via quarterly BPA contract monitoring. |  |
| Substance Abuse Treatment | SUD will use the developed assessment tools to gather baseline data on the existing SUD provider network and on the existing SUD service population by June 30, 2013 |  |
| Substance Abuse Treatment | SUD will draft a precise definition of eligibility criteria for IVDU |  |</p>
<table>
<thead>
<tr>
<th>Priority Area - Substance Abuse Treatment</th>
<th>SUD will train BPA staff to use this by 6/30/12.</th>
</tr>
</thead>
<tbody>
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<td>Priority Area - Substance Abuse Treatment</td>
<td>All new SA client information, including whether the person had a TB test in the past &amp; results of TB tests, will be data entered into WITS by 7/1/12. WITS will track TB status for clients with SA services by 6/30/13.</td>
</tr>
<tr>
<td>Priority Area - Substance Abuse Treatment</td>
<td>Identify a potential PWWC Region 2 provider by 6/30/12. Increase the PWWC provider network by at least one additional regional provider in Region 2 by 6/30/13.</td>
</tr>
<tr>
<td>Priority Area - Substance Abuse Treatment</td>
<td>Identify at least 2 potential adult SSH providers (Region 5 or 6) by 6/30/12. Approve at least one adult SSH provider in R 5 by 6/30/13.</td>
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<tr>
<td>Priority Area - Substance Abuse Treatment</td>
<td>SUD will develop a baseline for SUD client satisfaction using responses from the client satisfaction tool by June 30, 2013.</td>
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<td>Priority Area - Behavioral Health System Issues</td>
<td>FACS staff, including CPS liaisons and SUD program specialists will participate in at least three quarterly meetings to discuss issues related to collaborative service delivery and care coordination to clients with open child protection cases and SUD diag</td>
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<td>At least two (2) Safe and Sober Housing program beds for adolescents in each of three regions (Regions 1, 4 and 6) will be established and operational by June 30, 2012.</td>
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<td>Priority Area - Data and Quality Assurance</td>
<td>The functional data warehouse will allow cross walking, increased tracking, and interlinking capability between WITS and VistaA for DBH by June 30, 2012.</td>
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<td>DBH will test FEi produced enhancements and modules. FEi will migrate the final tested product into production by June 30, 2012.</td>
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<td>Priority Area - Data and Quality Assurance</td>
<td>DBH will establish timeline for implementation by June 30, 2012.</td>
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<td>Priority Area - Data and Quality Assurance</td>
<td>Each of seven (7) DBH regions will have at least one consumer survey kiosk installed and ready to use by June 30, 2012.</td>
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<tr>
<td>Priority Area - Substance Abuse Prevention</td>
<td>The DBH contract with the prevention services manager will require at least 25 evidence-based parenting education programs be offered to adults throughout Idaho. A minimum of 2 parenting education programs will be offered per region</td>
</tr>
</tbody>
</table>

**Footnotes:**
Please see entire Priorities, Goals, Strategies, and Performance Indicators attached above.
**Priority Area - Mental Health - Adults:** Idaho’s Division of Behavioral Health’s (DBH) Adult Mental Health (AMH) program will provide a comprehensive, consumer-driven, client-centered, recovery-focused continuum of care for adults with a serious mental illness (SMI) or a SMI and a co-occurring substance use disorder (SUD).

1. **Goal:** Consumers and family members will have input into the behavioral health service system planning and service implementation.
   
   a. **Strategy:** The DBH service centers will use Evidenced-Based Practices that promote consumer choice in all aspects of service delivery.

   i. **Performance Indicator:** DBH will continue to support at least 18 state and/or contract-employed Certified Peer Specialists through state general and federal grant funds through PATH, ID-HOPE, and ACT by June 30, 2013.

   ii. **Performance Indicator:** DBH will provide Treatment Plan training, including a focus on Person-Centered Planning, to DBH regional service delivery staff in each of seven (7) regional DBH service centers by June 30, 2013.

   b. **Strategy:** Consumers and family members will represent themselves and have input into delivery of Idaho’s Behavioral Health service system through memberships on state, regional, and community advisory boards.

   i. **Performance Indicator:** The Idaho Behavioral Health Advisory Council will include representation of adult consumers and family members of adult consumers according to federal requirements by June 30, 2013

   ii. **Performance Indicator:** Each Regional Behavioral Health Development Board will appoint representative consumers, family members, youth members according to federal requirements by June 30, 2013.

2. **Goal:** The state will implement the SSI/SSDI Outreach, Access, and Recovery (SOAR) program in three (3) of the seven (7) Department of Health and Welfare regions.

   a. **Strategy:** The State and Community SOAR Leads will educate the regions about SOAR and provide a protocol for the regions to follow as they develop the SOAR process in their communities.
i. Performance Indicator: At least one (1) Region will have appointed a Regional SOAR Lead, collaborated with their local Social Security Administration (SSA) office, and trained at least 25 Case managers by June 30, 2012.

ii. Performance Indicator: At least two (2) additional regions will have appointed a Regional SOAR Lead, collaborated with their local SSA office, and trained at least 25 case managers in their region by June 30, 2013.

iii. Performance Indicator: Idaho will use the SOAR data tracking system to establish a baseline of SOAR percentage of approvals by June 30, 2013.

3. Goal: Increase linkages for referral and collaboration between primary care providers and behavioral health care providers.

   a. Strategy: The DBH will meet with the Division of Public Health and primary care providers to identify collaborative opportunities to meet the needs of Idaho adults.

      i. Performance Indicator: The DBH will meet with the Division of Public Health and identify at least one (1) collaborative opportunity to meet the needs of Idaho adults served by both DBH and Public Health by June 30, 2013.

      ii. Performance Indicator: DBH will meet with the Idaho Primary Care Association at least two (2) times to identify needs of shared behavioral and primary health care adult clients and collaborative opportunities between programs by June 30, 2012.

      iii. Performance Indicator: The DBH will collaborate with at least one (1) primary care provider to identify at least one (1) combined project that could better address identified needs of adults with both behavioral and primary health care needs by June 30, 2013.

Priority Area -Mental Health - Children: Idaho will provide a comprehensive, family-driven, recovery-focused, client-centered continuum of care for families and children and youth with a serious emotional disorder (SED) with or without a co-occurring substance use disorder.

1. Goal: The Division of Behavioral Health (DBH) will implement parent support services for children with emotional and behavioral disturbances and their parents and families.

   a. Strategy: The DBH Family Supports Contract will help educate and prepare parents of children and adolescents with an emotional or behavioral disorder, including substance use, to become better advocates and representatives for themselves. This also includes educating and supporting children and adolescents with these disorders.
i. Performance Indicator: DBH will have a Family Supports Contract negotiated and ready to implement for the statewide provision of parent education/self-advocacy groups, parent support groups, youth education groups, and youth support/empowerment groups by June 30, 2012.

ii. Performance Indicator: The DBH Family Supports Contract will require implementation of at least 15 parent education/self-advocacy groups throughout the state by June 30, 2013.

iii. Performance Indicator: DBH Family Supports Contract will require implementation of at least 10 youth education/support groups for youth with emotional and behavioral disturbances by June 30, 2013.

b. Strategy: The DBH will provide respite services through the contract provider for parents of children with an emotional or behavioral disturbance.

i. Performance Indicator: DBH will negotiate a contract with a private provider for the provision of respite care services by June 30, 2012.

ii. Performance Indicator: DBH will contract with a private provider for the provision of respite care services to at least 200 families between SFY 2012 and SFY 2013.

c. Strategy: DBH will provide Idaho families with an Evidenced-Based parenting education curriculum: Parenting with Love and Limits (PLL).

i. Performance Indicator: The DBH will provide 150 families with PLL by June 30, 2012

ii. Performance Indicator: The DBH will provide 150 families with PLL between July 1, 2012 and June 30, 2013.

2. Goal: Increase awareness of mental health issues for children and families; decrease stigma and increase early access to information, education and other prevention activities.

   a. Strategy: The DBH Family Supports Contract requirements will include community outreach to youth groups to educate and create awareness of mental health issues.

   i. Performance Indicator: The DBH Family Supports Contract requirements will include mental health awareness/anti-stigma activities that are advertised in
various venues, including the schools and state agencies, throughout the state by June 30, 2013.

b. Strategy: The DBH Family Supports Contract requirements will include providing Idaho youth with emotional and behavioral disturbances with education and support groups throughout the state.

   i. Performance Indicator: The DBH Family Supports Contract requirements will include holding a minimum of one (1) support group per region in the state, every other month, for youth ages 8 through 19 with emotional or behavioral disturbances beginning in SFY 2012 and throughout SFY 2013.

   ii. Performance Indicator: The DBH Family Supports Contract requirements will include holding a minimum of one (1) education group per region in the state, every other month, for youth ages 8 through 19 with emotional or behavioral disturbances beginning in SFY 2012 and throughout SFY 2013.

3. Goal: Increase linkages between primary care providers and behavioral health care providers.

   a. Strategy: The DBH will meet with the Division of Public Health and primary care providers to identify collaborative opportunities to meet the needs of Idaho children and families.

      i. Performance Indicator: The DBH will meet with the Division of Public Health and identify at least one (1) collaborative opportunity and programs to meet the needs of Idaho children and their families who are served by both DBH and Public Health by June 30, 2013.

      ii. Performance Indicator: DBH will meet with the Idaho Primary Care Association at least two (2) times to identify needs of shared behavioral and primary health care child and family clients and collaborative opportunities between programs by June 30, 2012.

      iii. Performance Indicator: The DBH will collaborate with at least one (1) children’s pediatric primary care provider to identify at least one (1) combined project that could better address identified needs of children with both behavioral and primary health care needs by June 30, 2013.

**Priority Area- Substance Abuse Prevention:** Idaho will provide evidenced-based substance abuse prevention services for at-risk youth and parents.

1. Goal: DBH will contract with a provider manager to recruit, train, and maintain a provider pool in order to reduce the substance abuse rate in Idaho through prevention services.
Youth

a. Strategy: The DBH will contract with the substance abuse prevention provider who will be expected to fund community-based entities to deliver substance abuse prevention education to youth in general, to at-risk groups and to at-risk individuals.

   i. Performance Indicator: The DBH contract with the provider manager will require at least (1) evidence-based program in each of at least 30 Idaho elementary, middle schools, and high schools by July 30, 2012.

   ii. Performance Indicator: The DBH contract with the provider manager will require at least (1) evidence-based program in each of at least 30 Idaho elementary, middle schools, and high schools by June 30, 2013.

   iii. Performance Indicator: Identify baseline data for SFY 2012 for the number of Idahoans served in the prevention services program by June 30, 2012.

   iv. Performance Indicator: Seek to increase the total number of Idahoans served in the prevention services program, especially in the smaller cities and rural areas, from July 1, 2012 through June 30, 2013, using SFY 2012 data as a baseline.

b. Strategy: Increase the number of anti-alcohol/drug community coalitions.

   i. Performance Indicator: Idaho will have at least one anti-alcohol /drug community coalition per region by June 30, 2013.

c. Strategy: Continue to offer parent education materials to assist parents in communicating with their children and teens about substance abuse-related harm.

   i. Performance Indicator: The DBH contract with Boise State University will include providing access to Idaho Alcohol Drug Clearinghouse resource materials for substance abuse treatment and prevention professionals and the general public on substance abuse and prevention through the main office at Boise State University and also online, throughout SFY 2012 and SFY 2013.

   ii. Performance Indicator: The DBH, in partnership with the Office of Drug Policy, will provide prevention education to parents about alcohol and drug abuse issues that could affect their children through media campaigns throughout SFY 2012 and SFY 2013.

Parents/Adults

a. Strategy: The DBH will contract with a private provider manager who will be expected to fund community-based entities to deliver Evidenced Based prevention education resources for parents, and college students.
i. The DBH contract with a private provider manager will require at least 10 evidenced-based parent prevention education classes for parents with teens and 10 evidenced-based parent prevention education classes for parents with young children by June 30, 2013.

b. Strategy: The DBH will support a clearinghouse that will provider prevention education resources for youth, adults, parents and college students.

i. Performance Indicator: The DBH contract with Boise State University will include providing access to Idaho Alcohol Drug Clearinghouse for incoming Boise State students and the general public through the main office at Boise State University and online as a resource on substance education materials in SFY 2012 and SFY 2013.

**Priority Area - Substance Abuse Treatment:** Idaho will provide evidence-based substance abuse treatment services for youth and adults.

1. Goal: Develop a comprehensive plan for Substance Use Disorder (SUD) services to clients whose services are funded through Substance Abuse Prevention and Treatment (SAPT) block grant funds.

   a. Strategy: Develop treatment criteria for determining Level of Care (LOC), Length of Stay (LOS), and access to treatment.

      i. Performance Indicator: SUD will draft a written description of proposed benefit packages for clients whose services are funded through Substance Abuse Prevention and Treatment (SAPT) block grant funds by June 30, 2012.

      ii. Performance Indicator: SUD will develop a clinical algorithm that will distinguish levels of need and priority status for individuals requesting services by June 30, 2012.

      iii. Performance Indicator: SUD will use the algorithm to determine ongoing need for services and utilization management purposes for all SAPT funded SUD serviced by June 30, 2013.

      iv. Performance Indicator: SUD will develop an assessment tool to evaluate the existing SUD provider network and the existing SUD service population needs by June 30, 2012.

      v. Performance Indicator: SUD will use the developed assessment tools to gather baseline data on the existing SUD provider network and on the existing SUD service population by June 30, 2013.
vi. Performance Indicator: SUD will generate bi-monthly reports that include invoice detail, census and discharge data for monitoring treatment within clinical and financial boundaries by June 30, 2013.

b. Strategy: SUD will develop methods to control spending on clients whose services are funded through Substance Abuse Prevention and Treatment (SAPT) block grant funds.

i. Performance Indicator: SUD will develop a written document describing all DBH treatment criteria for eligible SUD individuals by June 30, 2012.

ii. Performance Indicator: SUD will generate bi-monthly reports to monitor level of care and length of stay related to SUD services. Reports will include invoice detail of expenditures, census and discharge data for monitoring SUD treatment by June 30, 2013.

2. Goal: SUD will collaborate with Family and Children’s Services (FACS) on the treatment of shared clients (i.e., clients with open child protection cases and SUD diagnoses).

a. Strategy: FACS staff (including Child Protection Services (CPS) Liaisons) will work with the DBH SUD program on issues related to clients with open child protection cases and SUD diagnoses through at least quarterly meetings.

i. Performance Indicator: FACS staff, including CPS liaisons and SUD program specialists will participate in at least three quarterly meetings to discuss issues related to collaborative service delivery and care coordination to clients with open child protection cases and SUD diagnoses by June 30, 2012.

ii. Performance Indicator: The SUD and FACS workgroup will develop a written guidance protocol to resolve issues related to clients with open child protection cases and SUD diagnoses by June 30, 2013.

3. Goal: SUD will begin to move the provider network to a more client-driven system of treatment based on the Recovery Oriented Systems of Care model of service delivery.

a. Strategy: SUD will develop written tools to evaluate provider service delivery and how well SUD services meet client needs, as measured by client responses to satisfaction surveys.

i. Performance Indicator: SUD will develop and define written provider performance measures (e.g., standards, indicators) and a written tool to measure provider performance by June 30, 2012.
ii. Performance Indicator: SUD will implement the provider tool with all SUD providers to measure provider performance; results for a baseline will be available by June 30, 2013.

iii. Performance Indicator: SUD will develop a written client satisfaction survey tool to evaluate satisfaction with treatment provider services by June 30, 2012.

iv. Performance Indicator: SUD will develop a baseline for SUD client satisfaction using responses from the client satisfaction tool by June 30, 2013.

b. Strategy: SUD will establish a workgroup that includes representation from DBH, juvenile corrections, adult corrections and the courts to improve collaborative service delivery to the shared provider network serving Idaho citizens with SUD.

i. Performance Indicator: SUD will establish workgroup purpose and parameters (e.g., identify partners, define and list purpose and goals) for this workgroup by June 30, 2012.

ii. Performance Indicator: The SUD collaborative workgroup will meet at least quarterly after startup by June 30, 2013.

Priority Area - Behavioral Health System Issues: In the next two years, the State Mental Health Planning Council will be replaced by the State Behavioral Health Council, and the Regional Mental Health Advisory Boards and Regional Advisory Councils (SUD) will merge to become Regional Behavioral Health Community Development Boards. The Behavioral Health Transformation Work Group’s proposed Array of Core Services (see Unmet Needs section) will be adopted and implemented for each region. As transformation progresses, Regions will be responsible to develop and implement approved Regional Transformation Plans that address unique needs and resources in each region.

1. Goal: By June 30, 2013, the Regional Mental Health Advisory Boards and Regional Advisory Councils (SUD) will merge to become Regional Behavioral Health Community Development Boards.

   a. Strategy: All Regional Advisory Councils and Regional Mental Health Boards will sunset by June 30, 2012. Both of these former types of councils/boards will merge to become Regional Behavioral Health Community Development Boards.

      i. Performance Indicator: Regional Behavioral Health Community Development Boards, or “Regional Boards,” will be established and operational in each DHW region by June 30, 2013.

      ii. Performance Indicator: The Regional Boards will identify regional needs, plans to develop regional capacity, and plans to provide input into regional behavioral health service provision by June 30, 2013.
2. Goal: By June 30, 2013, and as transformation progresses, regions will be responsible to develop and implement approved Regional Transformation Plans that address unique needs and resources in each region.
   
a. Strategy: Develop a Behavioral Health Interagency Cooperative (Cooperative) subcommittee to propose a structure for Regional Behavioral Health Development Boards (Regional Boards), including expectations of Regional Board roles and responsibilities.
   
i. Performance Indicator: A written report describing the proposed board structure, roles and responsibilities will be presented to the Cooperative by June 30, 2012.
   
b. Strategy: Test trial board structure in assigned regions for an indeterminate amount of time.
   
i. Performance Indicator: A final written report of the trial board strengths, challenges, and outcomes will be presented to Cooperative by June 30, 2013.
   
3. Goal: Evolve the role of the Division of Behavioral Health’s (DBH) Quality Assurance unit.
   
a. Strategies: By June 30, 2012, the DBH Quality Assurance unit will collaborate with Regional Mental Health Centers (RMHC) and Private Substance Use Providers (SUD) to develop a written quality improvement plan that defines the following:
   
   • Development of performance indicators that focus on quality of service, appropriateness of services and the pattern of utilization of services.
      a. each indicator must be specific with regard to:
         § what is being measured
         § how data will be collected
         § who is responsible for the data collection
         § what is the standard by which success will be measured
         § how the data will be reported
         § to whom the reporting will go.
   
   • Collection of meaningful data
      a. how to collect data (e.g. manual tracking forms, computer database, etc)
   
   • Reporting of data
      a. determine how often data will be reported (e.g. quarterly, semi-annually, annually)
      b. determine types of data to be reported (e.g. chronologically, trends, etc)
   
   • How to use the data for improvement across programs
   
   • Use of national benchmarking
      a. how to compare our programs to other programs (e.g. use of Benchmarking study run by the Institute for Behavioral Healthcare)
   
   i. Performance Indicator: The DBH Quality Assurance Unit will complete a written quality improvement plan for DBH services by June 30, 2012.
b. Strategy: By June 30, 2012, the DBH Quality Assurance Unit will partner with the National Alliance for the Mentally Ill (NAMI-Idaho), Office of Family and Consumer Affairs (OCAFA), Substance Use Disorder (SUD) Management Services contractor, Regional Mental Health Boards, and other MH/SUD Agencies to meet at least three (3) times at least quarterly for the purpose of establishing Regional Consumer Quality Review Teams. These teams will provide the following:

- face-to-face interviews with other consumers, family members, and providers
- focus on the five areas of service quality: availability, accessibility, acceptability, appropriateness, and adequacy
- SUD specific teams will focus on prevention/education, recognition, treatment, and maintenance
- MH specific teams will focus on access, process, and outcomes.

  i. Performance Indicator: At least seven (7) reviews per quarter are completed by the Regional Consumer Quality Review Team (one per quarter per region) beginning June 30, 2012 and continuing throughout SFY 2013.

c. Strategy: The DBH Quality Assurance unit will identify a reliable and valid tool for measuring outcomes, the timeframe for measurement (e.g. longitudinally at set intervals), and the process for implementation.

  i. Performance Indicator: An outcome monitoring tool is selected and implemented statewide for MH/SUD services to establish a baseline under the direction of the Division of Behavioral Health by June 30, 2012.

4. Goal: The Regional Behavioral Health Boards and the Division of Behavioral Health will make housing and employment resource development a priority for the homeless population.

a. Strategy: Identify additional sustainable resources for homeless individuals.

  i. Performance Indicator: The Idaho Home Outreach Program for Assistance in Transition from Homelessness (ID-HOPE) and the Office of Consumer and Family Affairs (OCAFA) will collaborate to implement the shared PATH to Housing plan to invite landlords in Regions 3 and 4 to meet to problem-solve solutions to identifying and retaining safe, affordable, supported housing for adults diagnosed with behavioral health issues. At least two (2) meetings with ID-HOPE, OCAFA and Region 3 and 4 landlords will be held by June 30, 2012. Another two meetings will be held between July 1, 2012 and June 30, 2013.

  ii. Performance Indicator: Projects for Assistance in Transition from Homelessness (PATH) Certified Peer Specialists will provide outreach and engagement to at least 500 adults across the State of Idaho who are literally homeless or at risk of becoming homeless, including at least 10 veterans, by June 30, 2012.
iii. Performance Indicator: At least two (2) Safe and Sober Housing program beds for adolescents in each of three regions (Regions 1, 4 and 6) will be established and operational by June 30, 2012.

b. Strategy: Connect homeless individuals to employment training resources.

i. Performance Indicator: The Idaho Home Outreach Program for Empowerment (ID-HOPE) project will link at least 30 eligible ID-HOPE project participants in Regions 3 and 4 to Idaho Vocational Rehabilitation (IDVR) Services or other employment resources by June 30, 2012. Another 30 will be linked to similar resources by June 30, 2013.

5. Goal: The DBH will provide a training curriculum for DBH service delivery staff on Gay, Lesbian, Transgender, Bisexual and Questioning cultural awareness.

a. Strategy: The DBH will develop a cultural awareness training module on GLTBQ cultural awareness that will be added to the DHW on-line Knowledge Learning Center site by June 30, 2012.

i. Performance Indicator: Regional DBH service delivery staff will be required to complete this training module on GLTBQ cultural awareness, which will include the need for awareness of the high risk of suicide of this population, by June 30, 2013.

6. Goal: Include Tribal leader representation on the State Mental Health Planning Council and in the DBH collaborative meetings.

a. Strategy: The State Mental Health Planning Council and the DBH will engage Tribal leadership and identify Tribal behavioral health needs and proposed solutions.

i. Performance Indicator: The State Mental Health Planning Council and the DBH will invite Tribal leaders to identify behavioral health needs and develop collaborative plans to address those needs by June 30, 2013.

ii. Performance Indicator: The State Mental Health Planning Council and the DBH collaborative meetings will include representation from Tribal leaders from at least two of Idaho’s six federally recognized Tribes by June 30, 2013.

Priority Area - Data and Quality Assurance: The State of Idaho will manage the public behavioral health system with a focus on quality assurance, service outcomes and development of a robust data infrastructure system capable of capturing and extracting data to help guide service system development and implementation.
1. Goal: Establish kiosks at regional behavioral health main offices and at both state hospitals to allow adults with serious mental illnesses and children with emotional and behavioral disorders and their parents to directly input responses to the adult Mental Health Statistical Improvement Program (MHSIP) and the Youth Satisfaction Surveys-Families (YSS-F) consumer surveys.

   a. Strategy: DBH and Information Technology (IT) will collaborate to develop an implementation plan for installing kiosks (including layout and cost analysis) at DBH regional program site locations.

      i. Performance Indicator: Each of seven (7) DBH regions will have at least one consumer survey kiosk installed and ready to use by June 30, 2012.

      ii. Performance Indicator: Each of two (2) state hospitals will have at least one consumer survey kiosk installed and ready to use by June 30, 2013.

      iii. Performance Indicator: There will be at least a 5% increase in submitted adult and youth/family consumer satisfaction surveys between June 30, 2012 and June 30, 2013.

      iv. Performance Indicator: A report of adult and youth/family satisfaction survey responses will be compiled into one annual report used to provide input into the delivery of behavioral health services by June 30, 2013.

   b. Strategy: DBH will train identified staff that will work with consumers in kiosk use. These staff will provide technical assistance and training as needed to help consumers (i.e., adults, children and family members) to access the kiosks.

      i. Performance Indicator: All identified DBH staff that will work with consumers will complete staff training on how to assist consumers with the kiosks by June 30, 2012.

2. Goal: DBH will complete the Web Infrastructure Information Technology System (WITS) implementation for Children’s Mental Health (CMH) for credible, non-duplicative data collection and report extraction of local, state and federal (e.g., State Outcome Measures State Outcome Measures (SOMS), and Treatment Episodes Data Sets (TEDS) reporting requirements.

   a. Strategy: DBH will direct Focus e-health Innovations Systems, (FEi) the contractor for the WITS data system, to complete modifications and enhancements to the WITS system that is specific to Idaho’s needs.

      i. Performance Indicator: DBH will test FEi produced enhancements and modules. FEi will migrate the final tested product into production by June 30, 2012.
ii. Performance Indicator: DBH will identify new enhancements; FEi will construct and build requirements by June 30, 2013.

iii. Performance Indicator: FEi will complete Dashboard and Data extract reports per requirements and they will be accepted by DBH by June, 30, 2012.

b. Strategy: DBH will maintain helpdesk access for statewide user group and hosting through FEi contract.
   i. Performance Indicator: FEi will be ready to provide secure web hosting and hourly back-ups by June 30, 2012.
   ii. Performance Indicator: DBH will create a Central Office WITS Helpdesk providing by June 30, 2012 and will provide ongoing support.
   iii. Performance Indicator: DBH will conduct Training of Regional Data Specialists in standardized entry and system enhancements by June 30, 2013.
   iv. Performance Indicator: DBH will develop a Data Entry Manual for CMH program staff use by June 30, 2012.

2. Goal: DBH will complete the WITS implementation for SUDS for credible, non-duplicative data collection and report extraction of local, state and federal (e.g., SOMS, TEDS) reporting requirements.

   a. Strategy: FEi will complete modifications and enhancements to the WITS system that are specific to Idaho’s DBH needs.
      i. Performance Indicator: SUD staff will determine which client programs in WITS need to be developed by June 30, 2012.
      ii. Performance Indicator: SUD staff, working with the contractor FEi, will identify and make needed enhancements for client programs by June 30, 2013.
      iii. Performance Indicator: SUD staff will identify reporting needs by June 30, 2012.
      iv. Performance Indicator: SUD staff will verify data collection of reporting needs in WITS by June 30, 2012.
      v. Performance Indicator: FEi will build needed reports to meet requirements in SSRS by June 30, 2012.

   b. Strategy: Develop WITS Implementation Plan for SUD providers
i. Performance Indicator: SUD staff will identify action items needed for implementation (e.g. training, entry guides, etc.) by June 30, 2012.


v. Performance Indicator: DBH will provide Implementation Plan to all DBH staff, contract providers, and SUD providers using the SUD WITS system by June 30, 2012.

vi. Performance Indicator: SUD staff working with the contractor FEi will draft WITS User Guidance by documents June 30, 2012.

c. Strategy: Develop training plans for Management Services Contractor (MSC) and SUD providers

   i. Performance Indicator: DBH will identify training needs, trainers, and training materials by June 30, 2012.

   ii. Performance Indicator: SUD staff working with the contractor FEi will schedule and train MSC by June 30, 2013.

   iii. Performance Indicator: SUD staff working with the contractor FEi will schedule and train providers by June 30, 2013.

3. Goal: Complete the data warehouse for behavioral health data (SUD, CMH, AMH)

   a. Strategy: DBH will develop a cross division data warehouse that will include the AMH, CMH, and SUD system called WITS, the state hospital system called VistA, and the former CMH and SUD systems.

      i. Performance Indicator: The functional data warehouse will allow cross walking, increased tracking, and interlinking capability between WITS and VistaA for DBH by June 30, 2012.

   b. Strategy: DBH will develop a divisional data dashboard that will include data from the National Outcome Measures (NOMS), utilization, and outcome data.

      i. Performance Indicator: Dashboard will be complete and posted to external website monthly by June 30, 2012.
Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America’s service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State’s suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.
Suicide Prevention

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America’s service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State’s suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

There is no nationally certified suicide prevention hot line in Idaho. The National Suicide Prevention Lifeline reported 3,700 calls from Idahoans in 2010. The Suicide Prevention Action Network of Idaho (SPAN Idaho) provided a suicide fact sheet in July 2010 based on data from the Idaho Bureau of Vital Records and Health Statistics, the Idaho Department of Health and Welfare, the Centers for Disease Control and Prevention and YRBS Idaho (see attached). According to these statistics, suicide is the 2nd leading cause of death for Idahoans 15-34 and for males 10-14 years of age. The fact sheet reports that in 2009, 307 people completed suicide, with 77% by men, and 58% involving a firearm. Also in 2009, “14.2% of Idaho youth attending traditional high schools reported seriously considering suicide in 2009,” with 6.9% reporting at least one attempt. The State Planning Council on Mental Health identified this as a top June 2011 concern.

The Department of Health and Welfare contracted with Idaho State University’s Institute of Rural Health to assess the need and viability of establishing an Idaho Suicide Hotline. This report can be accessed at www.isu.edu/irh/publications/Hotline_Report_2010_web_pwp.pdf. While a suicide hotline is a recognized need, challenges remain in identifying funding sources to establish and maintain operations for this type of resource. The Idaho Suicide Prevention Council (established in 2006) continues to actively collaborate with other agencies (e.g., Idaho National Guard, Idaho State University Institute of Rural Health, SPAN-Idaho, Mountain States Group and the Veteran’s Administration) to identify funding and resources to establish and implement a suicide prevention hotline.

Idaho’s Suicide Prevention Council developed a suicide prevention plan in 2003 (go to website http://healthandwelfare.idaho.gov/Portals/0/Children/DocumentsSrtView.pdf). In an effort to update this plan, a Suicide Prevention Plan Development Group met in July and August 2010 to discuss new suicide prevention challenges and collaboration opportunities. Representation was designed to be inclusive of a range of stakeholders, representation included former legislators, survivors, mental health consumers and their families, aging and adult care providers, youth and school services, public and private mental health providers and veteran’s mental health services, Native Americans, Hispanics and advocates for lesbian, gay, bisexual, and transgender (LGBT) persons. The Idaho Council on Suicide Prevention is in the process of finalizing the new plan which should be completed by November 2011. The Idaho State University of Rural Health has been instrumental in supporting and funding the development of the updated Idaho Suicide Prevention Plan.
IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:
Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:
Technical Assistance Needs

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

State, Providers, and Other Systems

Idaho’s technical assistance needs relate to data, collaboration with primary medical and dental agencies and use of technology to enhance the existing service delivery system, especially in rural and frontier areas. As of July 2011, the Division of Behavioral Health’s Web Infrastructure Treatment Services (WITS) system had been implemented for Adult Mental Health and Children’s Mental Health data needs. The Substance Use Disorders (SUDS) system was in the process of being developed, with a tentative implementation target date by the end of SFY 2012. The VistA system was used for both state hospitals, and it did not link to the WITS data system. Requirements for a data warehouse capable of allowing a crosswalk of WITS and VistA data was being developed, with an implementation target date for SFY 2012. Technical assistance would be helpful with respect to linking WITS and VistA with other stakeholders (e.g., Medicaid, corrections, primary medical and dental care).

One of the focus areas identified by the Idaho Behavioral Health Interagency Cooperative (IBHIC) to transform Idaho’s behavioral health care system is coordinating transformation activities with health care reform activities. Technical assistance in effective, cost efficient methods to do this could be useful.

The U.S. Census Bureau (2010) indicates that that Idaho’s population is 1,567,582, with 9 rural counties (i.e., no population center of 20,000 or more and six or more persons per square mile), 17 frontier counties (i.e., less than six per square mile) and 18 urban counties. In an effort to expand psychiatric services to rural and frontier areas that are unable to attract or retain a psychiatrist, the Idaho system has used video conferencing to provide tele-health. The high definition video conference system is also used for statewide meetings, including meetings of the State Planning Council on Mental Health. In SFY 2011, there was a cost savings for all video conference users (not just the Division of Behavioral Health) of $312,366.00. The SUDS system has been exploring the use of social media as an additional cost effective method of expanding treatment services. Technical assistance in this area may be helpful.

Persons Receiving Services, Persons in Recovery and Families

The economy has presented challenges for Idaho’s behavioral health service system. Use of peers as service providers can empower the peer, model recovery and serve as a cost effective paraprofessional service modality. As of July 2011, Certified Peer Specialists were working on Assertive Community Treatment (ACT) teams, Projects for Assistance in Transition from Homelessness (PATH) teams and on the Idaho Home Outreach Program for Empowerment (ID-HOPE) Critical Time Intervention (CTI) team.

Idaho peers received some technical assistance in SFY 2011. The Centers for Social Innovations provided technical assistance to PATH Certified Peer Specialists in Mental Health First Aid, Data, Outcomes and the PATH to Housing course. Some of the ID-HOPE staff also participated in the PATH to Housing course. The ID-HOPE project was chosen as a research site for teaching Critical Time Intervention skills, and this training occurred in June 2011. Technical assistance that may benefit persons receiving services, persons in recovery and families may include training in 1) advocacy techniques, 2) education, 3) combating stigma, and 4) peer operated programs, supports and other services that model recovery and resilience.
IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- Does the State sponsor meetings that specifically identify individual and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:
Involvement of Individuals and Families

States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)? Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs? Does the State sponsor meetings that specifically identify individual and family members’ issues and needs regarding the behavioral health service system and develop a process for addressing these concerns? How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system? How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Transformation

Idaho has been in the process of reviewing the behavioral health service system for several years with a focus on transforming the system such that “Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery.” Goals included the following: 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

Governor Otter signed Executive Order 2011-01 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. One charge to the IBHIC is to “d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho’s Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho’s budget, current needs of the agencies, and recommendations of the Idaho Health Care Council.” The IBHIC’s supplemental list of core services includes Peer Support Services.

Utilization of Individuals in Recovery and Family Members in Development and Implementation of Recovery Oriented Services

The Division of Behavioral Health uses some block grant funds to contract with Mountain States Group’s Office of Consumer and Family Affairs (OCAFA) to implement a Peer Certification program and to provide consumer and family member education and advocacy. The Certified Peer Specialist program began in SFY 2009. As of July 2011, there were 83 Peer Specialists who completed the training, with 68 of those passing the certification exam. Certified Peer Specialists are expected to complete their own Wellness Recovery Action Plans (WRAP) in addition to completing the 40 hour Peer Specialist Certification training. As of July 2011, there were 71 Peer Specialists trained in WRAP, 16 WRAP trained facilitators, and 25 Certified Peer Specialists trained in Peer Support Whole Health. The OCAFA supervises placement of Certified Peer Specialists as Assertive Community Treatment (ACT) staff and as Projects for Assistance in Transition from Homelessness (PATH) staff at each of the seven regional DBH service sites. All PATH staff are also SOAR trained to assist with benefits applications.
The OCAFA hired a family member in SFY 2011 to manage the consumer and family member education and advocacy activities; these activities include tracking and sharing information on legislative actions as well as coordinating with family groups (e.g., the National Alliance for the Mentally Ill for Idaho (NAMI-ID)).

Five Certified Peer Specialists are employed by private provider, Pioneer Health, as Critical Time Intervention (CTI) staff working on the state-contracted Idaho Home Outreach Program for Empowerment (ID-HOPE) pilot project in Regions 3 and 4. Through this program, Peer Specialists employed as outreach workers provide an assortment of services that include case management, crisis stabilization, assistance with SOAR applications, and helping participants find stable housing and/or employment. Besides helping others, Certified Peer Specialists also model recovery and resilience while working to achieve their own recovery goals.

The Substance Use Disorders program has explored the use of Recovery Mentors to model recovery, focus on wellness and encourage engagement in treatment services. The Division of Behavioral Health would like to continue to promote the use of peers as service providers.

The adult mental health system, delivered by the regions, uses person-centered planning to engage eligible program participants and partners to be involved in the intake and assessment process when developing the initial treatment plan and goals. The child mental health system also uses a person-centered planning process, which more often includes the family core (e.g., parents, siblings, guardian, etc.).

The Children’s Mental Health’s (CMH) comprehensive system of care is directed to family participation and involvement at all levels. Programmatic aspects include Parenting with Love and Limits (PLL), Wraparound and therapeutic foster care.

**State Sponsored Ongoing Training and Technical Assistance for Child, Adult and Family Mentors**

In SFY 2011, the OCAFA facilitated an assortment of training provided to the newly hired PATH Peer Specialists. A week long training in March 2011 addressed SAMHSA evidence based topic areas of Supportive Housing, Supported Employment, Family Psychoeducation and Co-Occurring Integrated Disorders. Additional March 2011 training covered PATH and cultural competency. The PATH and ID-HOPE staff participated in the Centers for Social Innovations PATH to Housing Course in May and June 2011. The PATH Peer Specialists attended another Center for Social Innovations technical assistance training opportunity in June 2011. The June training covered Mental Health First Aid and PATH data and outcomes.

As of July 2011, the Division was contracting with the non-profit Idaho Federation of Families to provide several educational and specialized family support services. Federation activities were supported through a combination of block grant and other funds. Activities in SFY 2011 included public training events on topics related to stigma, treatment and transition; regional Family Support Specialists that served as family
resources to help access CMH services; and use of the Youth Council that provided outreach and education on mental health issues to youth.

The Division of Behavioral Health’s contract with St. Luke’s Hospital for Primary Care Physician’s training is funded through a mix of block grant and other funds. One eight hour annual conference and monthly training events are offered for primary care physicians, other medical professionals and providers of mental health services on topics related to treating children and adolescents with mental health treatment needs.

The Division of Behavioral Health requires that all state employees working with adults, children, and families complete the “Cultural Diversity” course and the “Cultural Issues in Mental Health Treatment” course on the Knowledge and Learning Center (KLC) Website and also expects adherence to the state policy on Cultural Competency and Linguistics. An intensive Treatment Plan training will be completed in SFY 2012 for all clinicians who develop treatment plans. This training package emphasizes person-centered planning and matching client’s needs with their goals. Clinicians who develop treatment plans will be expected to complete this Treatment Plan training on the KLC in SFY 2012.

**State Sponsored Meetings Identifying Individual and Family Members Issues and Needs**

The State Mental Health Planning Council meets quarterly. The Council membership includes representation from adult consumers and child and adult family members. The Division of Behavioral Health uses some block grant funds for a Family Supports Contract. The SFY 2012 Request for Proposals (RFP) for this service requires that the contractor’s board include at least 51% family driven membership, with at least one child/youth member who has been diagnosed with a serious emotional disorder (SED).

Collaborative efforts with the Department of Juvenile Corrections include the Juvenile Justice Children’s Mental Health (JJCMH) meetings and Strengthening Families Round Table meetings. The JJCMH meets quarterly to resolve obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored implementation of a Youth Mental Health Court in three counties (as of July 2011) with interest in expansion to other counties. The Youth Mental Health Court uses the wraparound service model to facilitate treatment planning and coordination. The Strengthening Families Round Table meets every other month to brainstorm innovative ideas for family empowerment.

**Opportunities for Individuals and Family Members to Participate in Treatment Planning, Shared Decision Making and the Behavioral Health Service Delivery System**

All children, adults and families, along with the help of their clinician and/or case manager have input into the development of their treatment/recovery plan and in deciding what their treatment goals will be. This treatment planning usually occurs in a meeting between the clinician and the client and the client’s family, if applicable, after the assessment is complete. In addition, individuals, along with their clinician or case manager develop their own WRAP (Wellness Recovery Action Plan.) Family members
are often involved in the development of an individual adult’s WRAP because many times family members are key persons involved when emergency situations arise. In an effort to make it easier for consumers to complete the MHSIP and YSS-F satisfaction surveys, the Division of Behavioral Health plans to install kiosks for this purpose at all main regional service sites and at both state hospitals by June 30, 2013. Data from these surveys will be used to guide the system of care.

The Idaho Behavioral Health Interagency Cooperative (IBHIC) includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. The IBHIC is charged with guiding transformation of the public behavioral health service system. Plans include establishing a statewide Behavioral Health Council to replace the Councils that were directed to mental health and substance use disorders and replacing similar regional groups with one Behavioral Health Regional Development Board per region. Each regional board will be expected to develop a Regional Transformation Implementation Plan that describes the availability, quality, consistency and effectiveness of Initial and Supplemental Core Services and plans for addressing gaps in any of the service areas. As the system evolves, criteria based on these factors will be used to assess the “readiness” of a region to assume greater responsibility for the management of core services offered in the region.

State Support to Strengthen and Expand Recovery Organizations, Family Peer Advocacy, Self-Help Programs, Support Networks, and Recovery-Oriented Services

Idaho’s Division of Behavioral Health supports the use of Certified Peer Specialists in the Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) programs. Use of Certified Peer Specialists was expanded in SFY 2011 through a Projects for Assistance in Transition from Homelessness (PATH) grant to hire PATH Peer Specialists to provide up to 75% face-to-face outreach to adults with serious mental illness who were homeless at each regional Division of Behavioral Health site. In SFY 2011, the Division of Behavioral Health was awarded a Center for Mental Health Services Transformation grant to implement the Idaho Home Outreach Program for Empowerment (ID-HOPE) pilot project in Regions 3 and 4. This project is based on the evidence based practice of Critical Time Intervention (CTI), but the CTI team for ID-HOPE is made of a mix of bachelors/masters level staff and Certified Peer Specialists. The state also strongly supports the System of Care activities, and a new Request for Proposals will be available in SFY 2012 to identify a contractor to help support, empower, and teach families about the System of Care so they can learn to be better advocates for themselves.
IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:
**M. Use of Technology**

The following definition is used to guide Idaho’s responses to this section: “ICT is the back-and-forth dialog between the user and the computer. Games are always interactive, and most computer applications are interactive. The user selects a task, and the computer carries it out. Then the user selects another. Many Web pages are also interactive and increasingly function like locally installed applications. Not Interactive - A static Web page that has only links to other pages would not be considered interactive. In addition, a small utility program that performs one specific task may run without user interaction. After launching, the utility executes a set of instructions and exits.” Read more: [http://www.answers.com/topic/interactivity#ixzz1OibJBPf3](http://www.answers.com/topic/interactivity#ixzz1OibJBPf3).

**In the space below, please describe:**

**a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?**

The Division of Behavioral Health has deployed several strategies to support recovery in ways that leverage Interactive Communication Technology (ICT). One strategy includes use of high resolution video conferencing equipment for statewide meetings and for some telehealth medication monitoring services provided by psychiatrists to rural and frontier sites that have difficulty attracting and retaining adequate psychiatric staff. The Divisions of Behavioral Health, Family and Community Services and Self-Reliance all have equipment. Equipment is set up in all seven regions of the State of Idaho, at Central Office and at both State Hospitals.

The Department of Health and Welfare maintains a website. This website includes the use of dynamic forms that can be updated when there are changes. In SFY 2012, this side will include the addition of MHSIP and YSS-F Consumer Surveys that can be completed through survey monkey.

There are also other ICT uses. The Division of Behavioral Health helped design the FaceBook page for CMH Awareness Day. The Division of Behavioral Health has used GoToMeeting and Secure Meeting sites for meetings and training sessions. SharePoint use has allowed interactive user feedback and formation of a participant community of editors and donors. The SUD program researched the use of Social Media and presented at the June 2011 Idaho Conference on Alcohol and Drug Dependency (ICADD).

**b. What specific applications of ICTs does the State plan to promote over the next two years?**

During SFY 2012-2013, the Idaho Division of Behavioral Health plans to promote use of survey monkey to encourage online completion of MHSIP and YSS-F consumer surveys. Additional plans are to establish kiosks at Regional Mental Health Center sites to allow clients to complete surveys at the office.

**c. What incentives is the State planning to put in place to encourage their use?**

Other than increased ease of use of kiosks and survey monkey to complete consumer surveys, the Division of Behavioral Health has no specific planned incentives to encourage use of ICTs. The use of the video conferencing system is an established way to connect with other parts of the state (especially rural and frontier areas) in a cost effective and efficient manner for trainings, meetings and telehealth.

**d. What support systems does the State plan to provide to encourage their use?**
The addition of kiosks at Regional Mental Health Center sites will allow clients to complete surveys confidentially at the office location. As surveys may be filled out in conjunction with other appointments, this increases ease of use and likelihood of a higher consumer survey response rate. Increased consumer survey response feedback will help to guide services toward improved outcomes.

e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
There could be several barriers to implementing identified strategies. For example, there may be inadequate funds to support the costs of regionally located kiosks or other types of ICT equipment (palm pilots, laptops, etc). Challenges may arise with respect to implementing ICTs in light of state rules and/or regulations (e.g. setting up twitter, facebook, etc). Not all clients may have access to the computer or to the Internet. Some clients may not trust or understand the computer software or how to use a computer. The Division of Behavioral Health will address barriers to ICT implementation through continued education, advocacy and training of both public service staff and clients.

f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
As of July 2011, the Division of Behavioral Health did not have a formal plan to work with organizations such as FQHCs, hospitals, community based organizations and other local service providers to identify ways that ICTs could support the integration of mental health and addiction treatment services with primary care and emergency medicine.

g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
The MHSIP and YSS-F data will be used to help evaluate program effectiveness. The survey monkey method could also be used to collect other program evaluation data at the client and provider levels.

h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?
One measure that is used for judging effectiveness of the video conferencing equipment is the cost savings of holding meetings in this way as compared to paying for travel, lodging and per diem. Effectiveness of using survey monkey for MHSIP and YSS-F consumer surveys will be judged by the number of responses that are submitted compared to previous years when surveys were mailed. While the Idaho Department of Health and Welfare’s Division of Behavioral Health does not yet have a specific plan for measures and data collection to promote and judge use and effectiveness of all ICTs used, increased use of ICTs will result in development and implementation of data and outcome measures to judge use and effectiveness.
Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

• The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
• The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
• The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
• The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

Please see letters of support from Department of Corrections, Department of Juvenile Corrections, Division of Public Health, Family and Children's Services, Department of Education, and Division of Medicaid in the Attachments section.
Support of State Partners
The success of a State’s MHSBG and SAPTBG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

Idaho has been in the process of reviewing the public behavioral health service system (i.e., mental health and substance use prevention and treatment) for several years, with a focus on transforming the system such that “Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery.” Governor Otter signed Executive Order 2011-01 on January 27, 2011, which established the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) Counties. One charge to the IBHIC is to “d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho’s Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho’s budget, current needs of the agencies, and recommendations of the Idaho Health Care Council.”

State Education Agency
The Division of Behavioral Health recognizes the importance of collaborative relationships with the State Department of Education with respect to examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective factors for mental health and substance use disorders; and for those youth at-risk of emotional, behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.

The Division’s Children’s Mental Health (CMH) program and the Department of Education collaborate with local school districts to implement intensive community and school based programs for children and youth diagnosed with serious emotional disorders (SED). School programs range from traditional day treatment to classroom based models. Independent Idaho local school districts respond to the Individuals with Disabilities Education Act (IDEA) for eligible children. IDEA services include child find/referral, evaluation/eligibility, individualized education plans (IEP), related services, least restrictive environments, review and re-evaluation, transition requirements and consideration of behavior management needs.

The Special Education Advisory panel is a federally funded group within each state that provides feedback to the department of education on issues that impact special education consumers. The Division of Behavioral Health participates as a voting member of the Idaho panel during their quarterly meetings. The Department of Health and Welfare provides technical assistance and professional subject matter expertise on youth diagnosed with serious emotional and/or social disorders.

The Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) workgroup’s assessment is described in the “Idaho Substance Use Disorder Prevention and Treatment System: A Collaborative Strategy for 2008-2012.” One of the focus areas described in this report is collaboration
with the Department of Education to implement core best practice and outcome measures for substance abuse prevention services in grades K-12.

State Medicaid Agency

The Division of Behavioral Health is the Medicaid provider for Substance Use Disorder treatment services in Idaho, and these services are managed through a contract with Business Psychology Associates. The Division of Medicaid contracts with private providers for delivery of mental health services to Idaho children and adults.

Medicaid benefits were designed to be reflective of participants’ needs as a part of Medicaid Modernization. Three benefits plans, the Medicaid Basic Plan Benefits, the Medicaid Enhanced Plan Benefits and the Medicare/Medicaid Coordinated Plan Benefits were effective as of July 1, 2006. The Medicaid Medicare Coordinated Plan has been in effect since April 1, 2007. Blue Cross of Idaho started with their plan on April 1, 2007 and United Health Care started with their plan on May 1, 2007. Partial Care, Service Coordination and Psychosocial Rehabilitation mental health services are excluded from the Medicaid Basic Plan Benefits except for diagnostic and evaluation services to determine eligibility for these services. These services continue to be covered under the Medicaid Enhanced Plan Benefits. The services available in the Medicaid Enhanced Plan include the full range of services covered by the Idaho Medicaid program. Medicaid Basic Plan Benefit participants are limited to twenty-six (26) separate outpatient mental health clinic services annually and ten (10) psychiatric inpatient hospital days annually.

In SFY 2008, there were two major changes in Medicaid. Tele-health services were expanded to allow physicians to perform tele-health in any setting in which they are licensed. A benefit was added to allow for family therapy without the client present.

The availability of mental health services in the private sector has been affected by the economy. The Division of Medicaid implemented several strategies to control rising expenditures in Medicaid Mental Health services. Legislatively approved changes to clinic option rules included decreasing the number of partial care hours from 56 to 36 hours per week in 2004, with this benefit subsequently reduced to 12 hours per week in 2009. Psychosocial Rehabilitation (PSR) services were reduced from 20 to ten hours per week, and PSR crisis services were reduced from 20 to ten hours per week in 2009. In SFY 2010, House Bill (HB) 701 provided legislative intent for Medicaid program flexibility for FY 2011. The 2010 Idaho State Legislature approved Rules Governing Medicaid Cost-Sharing (IDAPA Chapter 16.03.18) that described the sliding scale, premium payments and premium waivers. Medicaid Omnibus Bill (HB 708) continued pricing freezes from SFY 2010 through SFY 2011; this bill allowed additional budget reductions. The 2010 Idaho legislature directed Medicaid to negotiate pricing and service changes with Medicaid providers to meet the projected $247 million budget deficit for SFY 2011. Medicaid solicited input in May 2010 about service reductions through www.MedicaidNeedsYourIdeas.dhw.idaho.gov. The 2011 legislature capped psychosocial rehabilitation services for adults 21 and older diagnosed with serious and persistent mental illness to four hours per week.

As of July 2011, Medicaid was pursuing a contract with a managed care organization (MCO) with a target implementation date of 7/1/12 for the administration of mental health benefits. A 1915b waiver will be in place as the funding authority to support the Managed Care Organization (MCO) contract. The Divisions of Behavioral Health and Medicaid collaborate with consumers and other state agencies to implement the “Money Follows the Person” Home Choice Program. In SFY 2012-2013, the Division of Medicaid will consult with the Division of Behavioral Health’s SMHA and SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
Health Insurance and Health Information Exchanges

In March 2010, the new health reform law (Patient Protection and Affordable Care Act; also called ACA) was enacted. It provides new options for coverage by expanding Medicaid eligibility to more low-income people and creating state-based health insurance “exchanges” through which insurance coverage can be purchased. The State of Idaho’s Department of Insurance (DOI) obtained a grant for Health Insurance Exchange planning in October 2010.

Idaho received a section 3013 grant for development of a health information exchange under the Health Information Technology for Economic and Clinical Health (HITECH) Act; the Idaho Health Data Exchange (IHDE) is the state designated entity for recipient of the grant funding. Operational as a Health Information Exchange (HIE) since 2009, the IHDE statewide health information organization includes a clinical data repository. Clinical staff at State Hospital North and State Hospital South can access the repository for clinical information (e.g., lab results) for patients they are treating. IHDE’s Security and Privacy Committee is reviewing the SAMHSA FAQs related to substance abuse confidentiality and health information exchange to determine IHDE’s next steps in this regard. IHDE, at the invitation of the behavioral health bureau chief, sent a staff member to the SAMHSA-Sponsored 2011 Health Information Technology Regional Forum to learn more about the issues and opportunities in this area.

While mental health and substance abuse data are not currently included in the exchange, the Division of Behavioral Health has had preliminary discussions with IHDE staff regarding integration of Behavioral Health information into the exchange. The Division of Behavioral Health plans to participate on IHDE’s privacy and confidentiality subcommittee in SFY 2012.

State Department of Justice

The Division of Behavioral Health works with the Department of Corrections and Department of Juvenile Corrections to 1) develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; 2) promote strategies for appropriate diversion and alternatives to incarceration; 3) provide screening and treatment; and 4) implement transition services for those individuals reentering the community.

As of July 2011, there were several established formats for collaboration between the Division of Behavioral Health and Juvenile Corrections. The Department of Health and Welfare has Memorandum of Agreements with the Department of Juvenile Corrections and all of the county administered juvenile detention facilities in the state for placement of clinicians in juvenile detention centers. Clinicians placed at juvenile detention centers assist with evaluations, service referrals and crisis counseling for both mental health and substance abuse. The State of Idaho uses some of the state general funds allocated to the Children’s Mental Health program to support the costs of those placements. Other collaborative efforts with the Department of Juvenile Corrections include the Juvenile Justice Children’s Mental Health (JJCMH) meetings and Strengthening Families Round Table meetings. The JJCMH, which includes members from county probation, Department of Juvenile Corrections, Department of Education, parent advocates, the court system, Department of Health and Welfare, and outside providers meets quarterly to resolve obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored dissemination on the implementation of a Youth Mental Health Court in three counties (as of July 2011) with interest in expansion to other counties. The Youth Mental Health Court uses the wraparound service model to facilitate treatment planning and coordination. The workgroup has adopted a definition of family involvement and is working on specific strategies for family involvement across systems. The Strengthening Families Round Table meets every other month to brainstorm innovative ideas for family empowerment and support.
Collaborative efforts with the Department of Correction and courts include service to individuals referred through mental health courts. The Division of Behavioral Health’s Adult Mental Health program serves eligible mental health court referred clients primarily through Assertive Community Treatment (ACT) teams in each region. ACT staff work closely with court representatives to develop individualized treatment plans for shared clients. Treatment plans are designed to help participants stabilize and learn additional life management skills (e.g., taking medications, ending drug/alcohol abuse, avoiding criminal activities). ACT staff attend weekly court sponsored meetings to discuss progress and needs of mental health court referred clients. During SFY 2009 and SFY 2010, Mental Health Court Utilization operated at approximately 90% of capacity. The Division of Behavioral Health’s Substance Use Disorders (SUD) program has Memorandum of Understandings with Idaho Department of Correction, Idaho Department of Juvenile Corrections and the courts for coordination of the delivery of SUD services to their respective populations.

Two laws passed in 2011 were relevant for drug court and/or mental health court participants. The first, HO225, allows for some persons charged with or convicted of a crime of violence to be admitted to drug court after consultation with the drug court team and with the consent of the prosecuting attorney. Law HO226 allows courts the option to allow a defendant on probation to have a felony conviction reduced to a misdemeanor upon a finding that such action was compatible with the public interest. Providing a chance for such defendants to have their convictions set aside offers incentive to abide by the terms of probation and increases employment and educational opportunities.

The Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) workgroup’s assessment is described in the “Idaho Substance Use Disorder Prevention and Treatment System: A Collaborative Strategy for 2008-2012.” It indicates that “The System addresses individual, community and tribal needs statewide for effective and accessible prevention, education, assessment, early intervention, treatment, recovery support services and post-treatment support,” (p. 3). It adds that the “System strives to maintain an uninterrupted, well-coordinated continuum of services to clients and their families within and outside of the criminal justice system.” Identified needs in the ICSA plan that were not complete by July 2011 (Appendices, p. 3, pp. 9-11) included collaboration with local and state correctional agencies and detention facilities to develop shared resource methods to ensure effective implementation and delivery of intervention and treatment services to adult and juvenile populations in correctional and detention facilities. Another goal identified in this report was to work with the Idaho Department of Correction and Juvenile Corrections and county probation to identify protocols to integrate treatment with probation services.

The 2012-2013 MHBG/SAPT Block Grant will focus on mental health and substance abuse prevention and treatment for children and adults. The Departments of Correction and Juvenile Corrections will continue to play a collaborative role in working toward achieving these goals through IBHIC efforts to implement the identified behavioral health transformation plan. The Division of Behavioral Health efforts will continue to collaborate with these Departments and with the courts to help individuals and families navigate the system of care continuum, prevent or divert from incarceration and facilitate smooth transitions for incarcerated individuals back into the community of choice.

**State Public Health Authority (Including Maternal and Child Health Agency)**

Medical services for children with SED may be funded by Medicaid, Children’s Health Insurance Program (CHIP), private insurance, county welfare services or private pay modalities. House Bill 376 (2003) directs that medical coverage be provided for children and adults with income between 150-185% of the Federal Poverty Guidelines. In response to this legislation, CHIP-B provides low cost health coverage to children without insurance who do not not qualify for either Medicaid or regular CHIP services.
Eligible children and families may access medical and preventative health services through the Idaho Department of Health and Welfare seven regional offices, through Idaho’s seven local public health districts, and other participating organizations and providers. Health districts collaborate with the Department of Health and Welfare and other state and local agencies. Each District has a Board of Health with members appointed by that district’s county commissioners.

Districts respond to local service needs, with some resource and service variation among districts and through contracts with the Department of Health and Welfare. Services may include community and home health nursing (i.e., family planning, immunizations, school-based nursing); environmental health; Women with Infants and Children’s (WIC) supplemental nutrition program for women, infants and children; and school-based oral health services (i.e., education, fluoride mouth rinse, fluoride varnish and sealants). Other partners, such as Delta Dental and Terry Riley Health Services, provide oral health services. While few Idaho dentists accept Medicaid, there are Idaho dentists that donate time to provide free dental care for children and low-income families. The Idaho Oral Health Alliance, a not-for-profit organization, is also working toward increased access to oral health care.

The Division of Public Health’s Bureau of Community and Environmental Health conducts a variety of health education and health promotion programs directed to encouraging healthy choices and healthy behaviors. Programs include adolescent pregnancy prevention, comprehensive cancer control, coordinated school health, diabetes prevention and control, environmental health (including a public listing of properties seized as clandestine drug laboratories), Fit and Fall Proof™ (fall prevention exercise for seniors), heart disease and stroke prevention, tobacco prevention, sexual violence prevention, Ichronic disease self-management, physical activity and nutrition, oral health and injury prevention and surveillance (i.e., contract for poison control services). The Bureau of Community and Environmental Health is actively working on programs to promote healthy communities and to address chronic disease self-management. Some of these areas are relevant to Idaho citizens from both primary and behavioral health perspectives. The Bureau of Community and Environmental Health’s past collaborative efforts with the Division of Behavioral Health include the SFY 2010 H1N1 Response Workgroup and the Substance Prevention and Treatment Tobacco Project.

The Division of Public Health and the Division of Behavioral Health actively participate in the Idaho Suicide Prevention Council and the recent development of the Idaho Suicide Prevention Plan. This relationship fostered a collaborative effort with the State Department of Education to address suicide prevention, intervention and post-vention in schools and local relationships between schools, law enforcement and regional Division of Behavioral Health staff. The Division of Public Health also provides emergency services, public health laboratory services, health preparedness and resource development (rural health), immunizations, food protection, epidemiology, Women’s Health Check, WIC, family planning/STD/AIDS, children’s special health and vital records and health statistics. Both Divisions welcome the opportunity to identify future collaborations and linkages that encourage primary and behavioral health care for Idaho citizens to address the whole person.

State Child Welfare/Human Services Department

The Division of Behavioral Health works with local child welfare agencies to address the trauma and mental and substance use disorders in families that often put their children at risk for maltreatment and subsequent out of home placement and involvement with the foster care system. The Department of Health and Welfare’s Division of Behavioral Health (DBH) focus is on program and policies related to behavioral health (i.e., adults diagnosed with serious mental illness, children with serious emotional disorders and adults and children with substance use disorder diagnoses). The Department’s Division of Family and Children’s Services (FACS) is responsible to manage issues related to child welfare, protection, foster care and adoption.
The Division of Behavioral Health has a designated program specialist that serves as a liaison between the DBH and FACS for consultation on issues related to accessing mental health services for children served through the child protection and adoption programs. The two Divisions collaborated on the design of a Treatment Foster Care program and an associated program to train Treatment Foster parents. Staff from both Divisions were trained on the Treatment Foster Care model and the training program for foster parents.

The DBH Substance Use Disorders (SUD) program has a designated SUD program specialist who serves as a liaison with FACS to help coordinate care for clients with open child care cases who also need substance abuse services. The SUD program has also partnered with FACS and the courts to develop three Child Protection Drug Courts (Regions 2, 5 and 6). These courts and all related treatment services are funded through a five year Regional Partnership federal grant that was awarded to the Division of Behavioral Health, and that will end in September 2012.

Representatives from the Division of Behavioral Health participated in the development of the Child and Family Services Review’s (CFSR) Program Improvement Plan (PIP) and also participated in on-site CFSR reviews. A Memorandum of Understanding between the DBH and FACS was signed 4/2011 regarding infant and early childhood mental health services (see DHW Infonet Children’s Mental Health at http://infonetdhw/Divisions/BehavioralHealth/ChildrensMentalHealth.aspx). Another Memorandum of Understanding outlines the process for coordinating services to children served in both programs. The Department’s Service Integration program facilitates family efforts to navigate the range of Department programs and services. The Service Integration program works with Idaho’s Health Information and Referral Center, or the 211-Idaho CareLine. The CareLine provides referral information (including housing and other resources) through the statewide 211 number.
IV: Narrative Plan

O. State Behavioral Health Advisory Council
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Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:
State Behavioral Health Advisory Council
Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHSBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State. Please complete the following forms regarding the membership of your State’s advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

As of August 2011, the State Planning Council on Mental Health and the Regional Mental Health Advisory Boards provided consultation on issues and services for persons diagnosed with a serious mental illness and/or a co-occurring substance use disorder. The Idaho State Planning Council on Mental Health’s responsibilities included participation in monitoring, reviewing and evaluating adequacy of services and providing review and input into the Mental Health Block Grant. During the next 21 months, the Idaho State Planning Council on Mental Health will change to reflect attention to behavioral health needs encompassing both mental health and substance use disorder issues and services.

For the past several years, Idaho has been reviewing the structure of the public behavioral health system. Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff’s Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision; “Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery. Goals included the following: 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

The BHTWG’s efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho’s Behavioral Health System (October 28, 2010). This report’s recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council to the State Behavioral Health Council; establishing the Behavioral Health Interagency Cooperative to oversee transformation efforts; and adopting the BHTWG’s proposed Array of Core Services “…as the ‘floor’ of services they seek to make available in each region.” The report recommends, “…that this array be maintained as the goal for regional planning and capacity building; and that also be used as a measure by which to indicate progress toward a truly transformed behavioral health system…” Core regional services recommended by the BHTWG include psychiatric emergency and crisis intervention services; assessments and evaluations; designated examinations and disposions; inpatient psychiatric hospitalization; medication management; case management; Assertive Community Treatment, intensive case management, Wraparound Services; psychotherapy; intensive outpatient; drug screening; alcohol and drug residential treatment; 24-hour out-of-home treatment interventions for children & adolescents; illness self-management; peer support; prevention; early intervention for children and adolescents; supported employment; supported housing; transportation; and day treatment, partial care and partial hospitalization.

Services will be provided in accordance with statewide standards which will include monitoring for quality, consistency, and effectiveness. The State Behavioral Health Authority will be responsible to develop and monitor the statewide standards of care for the initial and supplemental care services.
Each Behavioral Health Regional Development Board will be expected to develop a Regional Transformation Implementation Plan that describes the availability, quality, consistency and effectiveness of Initial and Supplemental Core Services and plans for addressing gaps in any of the service areas. As the system evolves, criteria based on these factors will be used to assess the “readiness” of a region to assume greater responsibility for the management of core services offered in the region.

Governor Otter signed Executive Order 2011-01 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. One charge to the IBHIC is to “d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho’s Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho’s budget, current needs of the agencies, and recommendations of the Idaho Health Care Council.”

As of 5/13/11, the IBHIC “to do” list was broken into four phases. All phases began with finalizing funding and ended with providing an annual status report to the Governor. **Phase 1** also included planning regional behavioral health development boards and state behavioral health planning council (e.g., identifying proposed membership, proposing an implementation timetable, soliciting and reviewing input and drafting legislation to implement regional behavioral health development boards to submit to the 2012 legislature); establishing core services for all regions and drafting 2012 legislation proposals; developing a transformation work plan, communications protocol and proposed transformation activity funding for SFY 2013; and reviewing SUDS treatment services and data report elements. Additional **Phase 2** activities included finalizing core services standards for the transformed behavioral health system; initiating regional transformation efforts and coordinating transformation activities with health care reform activities. **Phase 3** activities included developing a ‘Transformation Implementation Plan’ that applies to all Cooperative entities; developing regional Transformation Implementation Plans; monitoring and evaluating phase-in and recommending adjustments to State and Regional Transformation Plans; and coordinating transformation activities with health care reform activities. **Phase 4** included continuing phase-in of transformation, drafting legislation to implement the next phase; and coordinating transformation activities with health care reform activities.
### IV: Narrative Plan

#### Table 11 List of Advisory Council Members

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<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
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<tbody>
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<td>Region VI MH Advisory Board</td>
<td>Idaho State University-College of Health, Box 8090-CD186, Pocatello, ID 83209, Phone: 208-221-6306</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:dennkati@isu.edu">dennkati@isu.edu</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes:
## IV: Narrative Plan

### Table 12 Behavioral Health Advisory Council Composition by Type of Member

Page 52 of the Application Guidance

<table>
<thead>
<tr>
<th>Start Year:</th>
<th>End Year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>2013</td>
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</table>

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Total Membership</td>
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</tr>
<tr>
<td>Individuals in Recovery (from Mental Illness and Addictions)</td>
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<td></td>
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<tr>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
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<td></td>
</tr>
<tr>
<td>Vacancies (Individuals and Family Members)</td>
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<td></td>
</tr>
<tr>
<td>Others (Not State employees or providers)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
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<td>50%</td>
</tr>
<tr>
<td>State Employees</td>
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<tr>
<td>Providers</td>
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<td>Leading State Experts</td>
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<tr>
<td>Federally Recognized Tribe Representatives</td>
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<tr>
<td>Vacancies</td>
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<td></td>
</tr>
<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
<td>10</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Footnotes:**
Narrative Question:
SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.
Comment on the State Plan

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

The Idaho Division of Behavioral Health values public comment on the State SAPT/MHBG block grant Plan for 2012-2013. Several opportunities for input were provided for public comment from an assortment of stakeholders during plan development.

Efforts were made to work with identified state partners that collaborate to serve Idaho citizens receiving SMHA or SSA behavioral health services. Discussion and letters of support were obtained from multiple other collaborating agencies (see attachments and Support of State Partners section).

The read-only WebBGAS login was provided to multiple stakeholders as soon as it was available. Stakeholders included the State Planning Council on Mental Health, the Office of Consumer and Family Affairs, the Federation of Families and regional Division of Behavioral Health offices. Regional sites and Planning Council members were encouraged to share login information with Regional boards and other mental health and substance abuse providers and resources. Comments were sent to Heidi Lasser and Cynthia Clapper, the 2012-2013 Idaho State Planners for the combined block grant application.

The State Planning Council on Mental Health discussed the block grant application during their August 23, 2011 meeting. As appropriate, comments and plan revisions were included in the final product.
A Profile of Idaho’s FY10 Data from the Global Appraisal of Individual Needs (GAIN)

Michael Dennis, Ph.D. & Kathryn Modisette - Chestnut Health Systems, Normal, IL January 27, 2011 Presentation to the Idaho Office of Drug Policy. This presentation uses data collected by Idaho providers as part of the state mandate to use a common assessment across programs. The opinions are those of the author and do not reflect official positions of the government. Comments or questions about this report can be addressed to Michael Dennis, Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761, phone 309-451-7801, fax 309-451-7765, e-Mail: mdennis@Chestnut.Org Questions about the GAIN can also be sent to gaininfo@chestnut.org

Preliminary Findings from Idaho GAIN data for Fiscal Year 2010 (7/1/2009 to 6/30/2010)
In 2007 the state initiated the process of implementing a common assessment approach using the Global Appraisal of Individual Needs (GAIN) developed by Chestnut Health Systems and in use in 49 states, DC, PR, GU and 7 other countries. Providers in Idaho were trained by a combination of regional trainers and Chestnut staff between 2007 and 2008. In 2009 staff started using version 5.6 with a web-based software to assist with the interviewing Idaho Staff Trained by FY2010; certificates (319 site interviewers; 536 coursework; 278 administrators; 71 local trainers; 2 regional trainers (total 1,206)

Grouping Sites by Case Mix Index - Data used here are 4,815 clients intaked by 51 providers collected in fiscal year 2010 (7/1/2009 – 6/30/2010). A case mix index was created for each person based on the percentage of 12 common problems they presented to treatment with. The average of this case mix index was used to rank order providers and then divide them into four groups associated with increasing severity. The next slides show the 12 problems and how the providers collapse into the case mix groups. In latter slides these case mix groups will be cross with several specific problems.

12 Common Problems Used in Case Mix: Alcohol 61%; Cannibis 41%; Other drug disorder 57%; Depression 50%; Anxiety 32%; Trauma 40%; ADHD 36%; CD 27%; Suicide 20%; Victimization 73%; Violence/Illegal Activity 67% (Source Idaho Data Set 6/30/10 – n = 4,867)

Intake Characteristics: The next slides show demographic characteristics and clinical problems that clients presented with. Data used here are 4,815 clients intaked by 51 providers collected in fiscal year 2010 (7/1/2009 – 6/30/2010). For selected variables this includes how they break out by gender, race, age and case mix group. Where applicable, odds ratio is given for most severe group over least severe group.

Demographic characteristics: female 37%; African American 10%; Caucasian 76%; Hispanic 14%; Mixed/other 12%. Ages 0-14 - 2%; 15-17 – 12%; 18-25 – 28%; 26-49 – 52%; 50+ 6% (Source Idaho Data Set 6/30/10 n=4,815), Sample predominantly male Caucasian aged 26-49.

Pattern of Weekly Use (13+/90 days) Anything 40%; alcohol 16%; cannabis 15%; cocaine 1%; opioid 8%; amphetamine 12%; other drugs 4%; needle use 16%; tobacco 69%; controlled environment 39% (Source Idaho Data Set 6/30/10 n=4,747)

Co-occurring Psychiatric Problems: any 59%; conduct disorder 42%; ADHD 36%; major depressive disorder 28%; traumatic stress disorder 22%; general anxiety disorder 11%; ever phys/sx/emot victimization 61%; ever homeless/runaway 36%; any homicidal/suicidal thoughts past year 23%; any self mutilation 11%; prior MH treatment 37% (Source ID data set 6/30/10 n=4,653)

Recovery Environment – Home: family history of SU 82%; weekly alc use at home 16%; weekly drug use at home 10%; weekly family problems 7%

Recovery Environment – Peers: social peers drunk weekly 39%; school/work peers drunk weekly 20%; others@home drunk weekly 26%; social peers using drugs 35%; school/work peers using drugs 15%; others@home using drugs 21% (Source ID data set 6/30/10 n=4,541)

General Victimization Scale (GVS): ever attacked w/gun, knife, other weapon 44%; ever hurt by striking/beating 53%; abused emotionally 51%; ever forced sex against will 22%; age of 1st abuse <18 53%; any w/> 1 person 35%; any several times or long time 49%; person family/trusted 47%; afraid for life/injury 35%; people told did not believe/help 18%; result in oral/vag/anal sex 20%; now worried someone attack 5%; now worried someone beat/hurt 6%; now worried someone abuse emotionally 10%; now worried someone force sex acts 1% (Source ID data set 6/30/10 n= 4,582)
Past 90 Day HIV Risk Behaviors: sexually active 65%; multiple sex partners 16%; any unprotected sex 41%; high risk sex (1+ times while intoxicated, w/IV drug user, w/man who had sex w/men, w/someone HIV+ or traded sex for goods n=415); victimized 11%; worried- forced sex acts 1%; any needle use 16% (Source ID data set 6-30-10 n= 4,328)

Past Year Violence & Crime: any violence/illegal activity 67%; physical violence 45%; illegal activity 52%; property crimes 23%; other drug related crimes (dealing, manufacturing, prostitution, gambling) 40%; interpersonal/violent crime 18%; lifetime juv justice involvemt 96%; current juv just involvement 87%; 1+/90 days in controlled environment 61% (Source ID data set 6-30-10 n=4,699)

Intensity of Justice System Involvement (JSI): detention/jail 30+ days 26%; detention/jail 14-29 days 8%; probation/parole 14+ days w/1+ drug screens 25%; other probation/parole/detention 16%; other JSI status 13%; past arrest/JSI status 8%; past year illegal activity/SA Use 4% (source ID data set 6-30-10 n=4,317)

Implications: Relative to the US, clients entering treatment in Idaho are more likely to have amphetamine or opioid diagnoses and needle use; Co-occurring mental health diagnoses and other problems are the norm and go up with the case mix severity; Higher rates of victimization appear to be particularly powerful predictors of multiple co-occurring problems; There may be opportunities to target homeless people

Costs to Society: The cost of each client to society in the quarter before intake was estimated based the frequency of using tangible services in the 90 days before intake (e.g., health care utilization, days in detention, probation, parole, days of missed school) in each of the 8 areas valued in 2009 dollars, and summed. Quarterly costs to society can be used continuously with higher values indicating more expense to society. It can also be triaged as low ($0 to $1999), moderate ($2000 to $9999) and high ($10000 or more) based on average costs of outpatient and residential treatment respectively.

Average and Total Costs to Society: Quarterly cost to society data could be estimated for 3,717 clients (those missing any item were dropped). In the quarter before they entered treatment, they cost society an average of $4,695 per client and a total of $17,449,739 across clients. In the year before they entered treatment, they cost society an average of $18,780 per client and a total of $69,798,956 across clients.

Intoxication/Withdrawal Common Treatment Planning Needs: detox/withdrawal 29%; ambulatory detox 13%; meds for non-opioid w/drawal & relapse 10%; meds for opiate withdrawal & relapse 3%; monitoring withdrawal & AOD meds compliance 2% (source ID data set 6-30-10 n=4,788)

Biomedical common treatment planning needs: risky sex behavior 82%; tobacco cessation 68%; ER/hospitalization history 39%; accommodate medical condition 39%; compliance w/PH meds 37%; compliance w/MH meds 31%; meds for physical health problems 26%; current tx for medical problem 26%; needle use 24%; tetanus shot 12% (source ID data set 6/30/10 n=4,481).

Psychological Common Treatment Planning Needs: coord w/justice system 89%; behavior control 58%; arrest history 46%; anger mgmt 34%; drug-related illegal activities 32%; homicidal/suicidal risk 29%; current meds for psych problems 29%; current tx for psych problems 27%; civil court 22%; problems w/reading/writing 12% (source ID data set 6-30-10 n=4,509)

Readiness Common Treatment Planning Needs: case mgmt 82%; any tx pressure 69%; tx required 48%; dissatisfaction w/past 90 day tx 8%; review expectations for length of tx 6% (source ID data n=3,803)

Relapse Potential Common Treatment Planning Needs: recovery coach 61%; cc after controlled environment 42%; significant time in controlled env 39%; discuss SA tx history 5% n=4,637

Environment Common Treatment Planning Needs: coping w/stress 87%; env risk 79%; need for change 73%; child maltreatment 73%; regain custody of minor children 52%; financial counseling 51%; other voc help 48%; employed past 90 days 40%; housing situation 39%; family fighting 30% SU in home 23% school or GED program 22% n=3,873

Other priority populations: dual dx 92%; publicly funded health insurance 87%; below poverty line 75%; no health ins 61%; unemployment 40%; disability compensation 14%; CWS involvement 11%; TANF benefits 7%; physical disability 6%; homelessness 5%; veteran 4% n=3,919

Example of exploring need, unmet need and targeting of MH services in AAFT:
After 3 mon (at intake) | No/low need | Mod/high need | Total
---|---|---|---
Any treatment | 6 | 218 | 224
218/224 = 97% to targeted
No treatment | 205 | 553 | 758
553/771 = 72% unmet need
Total | 211 | 771 | 982
771/982 = 79% in need

Problem size; extent services not reaching most in need; extent services being targeted

Mental Health Problem at intake vs. Any MH treatment by 3 months; 79% clients with mod/high need (3+ on ASAM B3 criteria; n=771/982); 72% w/need but no service after 3 mos (n=553/771); 97% services going to those in need (n=218/224) Source; 2008 CSAT AAFT Summary Analytic Data Set

**Why do we care about unmet need?**  If we subset to those in need, getting mental health services predicts reduced mental health problems. Both psychosocial and medication interventions are associated with reduced problems. If we subset to those NOT in need, getting mental health services does NOT predict change in mental health problems. Conversely, we also care about services being poorly targeted to those in need.

**Residential Treatment Need (at Intake) vs. 7+ Residential Days at 3 Months:** 36% clients w/mod/high need n=349/980; 90% w/need but no service after 3 mos n=315/349; 52% services going to those in need n=34/66 – opportunity to redirect existing funds through better targeting (source 2008 CSAT AAFT summary analytic data set)
Suicide in Idaho: Fact Sheet
July 2010

- Suicide is the 2nd leading cause of death for Idahoans age 15-34 and for males age 10-14. (The leading cause of death is accidents.)
- Idaho is consistently among the states with the highest suicide rates. In 2007 (the most recent year available) Idaho had the 11th highest suicide rate, 28% higher than the national average.
- In 2009, 307 people completed suicide in Idaho; a 22% increase over 2008, and a 40% increase over 2007.
- In 2009, 77% of suicides were by men.
- In 2009, 58% of Idaho suicides involved a firearm. The national average = 50%.
- 14.2% of Idaho youth attending traditional high schools reported seriously considering suicide in 2009. 6.9% reported making at least one attempt.
- In 2007, there were 34,600 deaths by suicide in the United States, an average of 1 person every 15 minutes.
- In 2000, the suicides of those under 25 years of age in Idaho resulted in estimated direct costs of $3.77 million, and lost earnings of $81 million.
- Between 2005 and 2009, 74 Idaho school children (age 18 and under) died by suicide.

### Idaho Suicides by Region – 2009

<table>
<thead>
<tr>
<th>Region</th>
<th>City</th>
<th>Suicides</th>
<th>Rate (per 100,000)</th>
<th>Population</th>
<th>Tot. # suicides 2005-2009</th>
<th>5-yr Avg Rate</th>
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<tbody>
<tr>
<td>1</td>
<td>CDA</td>
<td>52</td>
<td>24.3*</td>
<td>213,662</td>
<td>268</td>
<td>25.7</td>
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<td>2</td>
<td>Lew</td>
<td>19</td>
<td>18.2*</td>
<td>104,496</td>
<td>102</td>
<td>19.9</td>
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<td>3</td>
<td>Nampa</td>
<td>43</td>
<td>17.1*</td>
<td>251,013</td>
<td>204</td>
<td>16.8</td>
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<td>4</td>
<td>Boise</td>
<td>64</td>
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<td>429,647</td>
<td>344</td>
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<td>5</td>
<td>Twin</td>
<td>49</td>
<td>27.2*</td>
<td>179,994</td>
<td>181</td>
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<tr>
<td>6</td>
<td>Pocatello</td>
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<td>7</td>
<td>Id Falls</td>
<td>44</td>
<td>21.7*</td>
<td>202,463</td>
<td>190</td>
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</table>

* increase from 2008,  - decrease from 2008

### Idaho Suicides by Age/Gender 2005-09

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<th>Age</th>
<th>Total</th>
<th>Male</th>
<th>Rate</th>
<th>Female</th>
<th>Rate</th>
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<td>10-14</td>
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<td>1.1</td>
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<td>15-19</td>
<td>81</td>
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<td>4.0</td>
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<td>117</td>
<td>101</td>
<td>36.2</td>
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<td>6.6</td>
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<td>25-34</td>
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<td>165</td>
<td>30.6</td>
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<td>35-44</td>
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<td>42.4</td>
<td>64</td>
<td>13.4</td>
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<td>40</td>
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<table>
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<tr>
<th>Method 2005-09 (all ages)</th>
<th>Idaho Suicide Rates 1998 – 2009</th>
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<tbody>
<tr>
<td>Year</td>
<td>Number</td>
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<tr>
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<td>2000</td>
<td>166</td>
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<td>2001</td>
<td>213</td>
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<td>2002</td>
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<td>2003</td>
<td>218</td>
</tr>
<tr>
<td>2004</td>
<td>239</td>
</tr>
<tr>
<td>2005</td>
<td>225</td>
</tr>
<tr>
<td>2006</td>
<td>218</td>
</tr>
<tr>
<td>2007</td>
<td>220</td>
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<tr>
<td>2008</td>
<td>251</td>
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<tr>
<td>2009</td>
<td>307</td>
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Idaho OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014
Idaho Youth Risk Behavior Survey 2009 – High School Students

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<th>Grade</th>
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<th>Suicidal</th>
<th>Plan</th>
<th>Attempt</th>
<th>Medical Care For Attempt</th>
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<tr>
<td>9th</td>
<td>27.3%*</td>
<td>12.7%-</td>
<td>12.2%-</td>
<td>5.9%-</td>
<td>1.8%-</td>
</tr>
<tr>
<td>10th</td>
<td>29.5-</td>
<td>17.9-</td>
<td>14.6*</td>
<td>9.7</td>
<td>2.6-</td>
</tr>
<tr>
<td>11th</td>
<td>30.2*</td>
<td>13.3-</td>
<td>14.3*</td>
<td>6.2-</td>
<td>1.6-</td>
</tr>
<tr>
<td>12th</td>
<td>26.0-</td>
<td>12.3-</td>
<td>12.0-</td>
<td>5.5-</td>
<td>2.0*</td>
</tr>
<tr>
<td>Idaho Overall</td>
<td>28.3</td>
<td>14.2-</td>
<td>13.3*</td>
<td>6.9-</td>
<td>2.0-</td>
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</table>

* increase from 2007, - decrease from 2007

Idaho Suicide Rate By County

5-year average 2005-2009
(suicides per 100,000 people)

<table>
<thead>
<tr>
<th>County</th>
<th>Number</th>
<th>Rate</th>
<th>County</th>
<th>Number</th>
<th>Rate</th>
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<td>Gooding</td>
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<td>11.2</td>
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<tr>
<td>Bannock</td>
<td>72</td>
<td>18.0</td>
<td>Idaho</td>
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<td>19.6</td>
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<td>Latah</td>
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<td>Lewis</td>
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<td>Lincoln</td>
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<td>22.2</td>
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<td>Boundary</td>
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<td>2</td>
<td>14.4</td>
<td>Minidoka</td>
<td>18</td>
<td>19.4</td>
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<td>Camas</td>
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<td>54.4</td>
<td>Nez Perce</td>
<td>44</td>
<td>22.6</td>
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<td>141</td>
<td>15.7</td>
<td>Oneida</td>
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<td>14.6</td>
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Idaho (total) | 1,446 | 19.3 (5-year average)

Sources: Idaho Bureau of Vital Records and Health Statistics
Idaho Department Health and Welfare
Center for Disease Control and Prevention
YRBS Idaho, 2009

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Special Thanks to Katey Anderson, Senior Research Analyst, Bureau of Vital Records and Health Statistics
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2009-2010

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Summary List of Recommendations

**Director of Transformation**

BHTWG recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislature that establishes the Behavioral Health Transformation Office (BHTO) and the position of Director of Transformation to direct that office in a manner consistent with the roles and responsibilities outlined in the Director of Transformation job description presented in the BHTWG Plan for the Transformation of Idaho's Behavioral Health System, October 28, 2010. The Director of Transformation is specifically intended to act as a daily and continuous champion for the transformation effort on a local, regional and state level.

Furthermore, BHTWG recommends that the BHTWG, Cooperative, and Interagency Committee on Substance Abuse Prevention and Treatment forward the names of prospective candidates who meet the requirements of the position for appointment by the Governor.

The BHTO and the Director of Transformation function are recommended for review in 2016, with a potential sunset or continuation of the Office and position depending on the outcome of that review.

**Regional Behavioral Health Community Development Boards**

BHTWG recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislature, in anticipation that Regional Behavioral Health Community Development Boards be established and populated during 2011 and functional by December 2011. The establishment of Regional Behavioral Health Community Development Boards eliminates the need for the existing Regional Mental Health Advisory Boards and the Regional Advisory Councils.

**State Behavioral Health Planning Council**

BHTWG recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislature in order to modify the role of the State Mental Health Planning Council to one that has a behavioral health focus and is called the State Behavioral Health Planning Council, fulfills the requirements of federal law, includes representation from each of the Regional Boards, and limits the group's membership to a representative but efficient number.

**Statewide Behavioral Health Interagency Cooperative**

BHTWG recommends that the Governor's Office issue an Executive Order to activate the Statewide Behavioral Health Cooperative and its responsibilities in response to the delivery of this Plan.

This action ensures that the momentum generated by the BHTWG and the completion of specific activities as proposed in this Plan are accomplished. These activities include identifying prospective candidates as the Director of Transformation, reviewing and supporting draft legislation to implement the transformation structure, and serving as a point of contact and information for regional stakeholders until that time the Director of Transformation is secured. The Executive Order is recommended to require a review of the need for the Cooperative again in 2016, with a potential sunset or continuation of the Cooperative depending on the outcome of that review.
BHTWG also recommends that legislation be drafted and presented to the 2011 session of the Idaho State Legislature to legislatively enact the Cooperative as described by the Executive Order concurrently with the sunset of ICSA in June.

**State Behavioral Health Authority**

BHTWG recommends that the Idaho Department of Health and Welfare continue to function as the State Behavioral Health Authority, and to coordinate and communicate the status of that effort and scope as described in the BHTWG Plan for the Transformation of Idaho's Behavioral Health System October 28, 2010 within the context of the Cooperative.

**Regional Provider Networks**

BHTWG recommends that the structure proposed to be established via Executive Order in 2010 and Legislation in 2011 be so established, tasking that structure with the continued development of transformation and the associated standards, data, need, priorities and funding coordination that will further inform the development of a delivery system featuring Regional Provider Networks.

**Array of Core Services**

BHTWG recommends that the regions and the state adopt the Array of Core Services proposed in the BHTWG's Plan for the Transformation of Idaho's Behavioral Health System October 28, 2010 as the "floor" of services they seek to make available in each region; that this array be maintained as the goal for regional planning and capacity building; and that it also be used as a measure by which to indicate progress toward a truly transformed behavioral health system over the long term.
Introduction

The Behavioral Health Transformation Work Group (BHTWG) was tasked in Executive Orders 2009-04 and 2010-01 to generate a plan for a "coordinated, efficient state behavioral health infrastructure with clear responsibilities, leadership authority and action," and to "provide for stakeholder participation in the development and evaluation of the plan."

This initiative was undertaken in response to issues associated with the existing mental health and substance use disorder systems which feature inconsistent service standards, reliance on the use of high cost crisis and hospitalization services or incarceration given the lack of adequate community supports, and the recognition that 50 to 70 percent of people with mental health or substance use disorders have co-occurring symptoms. The existing systems, already costly, suffer even more because the two systems are operated separately, creating fragmentation of services and duplication of efforts. Additionally, the ability to meet mental health and substance use disorder needs, already challenging, is even more difficult in current economic times featuring shrinking state and personal resources.

Consumers and families already suffer from the lack of services and service providers, closing of Department of Health and Welfare (DHW) offices, and short Medicaid resources. Given the current economic downturn, they fear even greater loss. Stakeholders are frustrated by their inability to understand the collective need and manage the cost of that need, as well as by their inability to leverage their collective resources in the most meaningful way.

The BHTWG proposes a structure and process that moves the state toward an accessible, consistent and effective system in spite of the current economic situation and in a manner that generates a more robust system should the economy recover. What's more, BHTWG recognizes that Health Care Reform will likely produce a substantive increase of people with access to behavioral health services in 2016, and Idaho needs to generate the capacity and systems to support that possibility.

From May 2009 through October 2010 the BHTWG worked to generate this Plan that commits the State of Idaho to the process of developing an efficient and effective client-centered system. Rather than starting over, BHTWG specifically opted to use the results and recommendations of previous work in this area to inform their proposed action. BHTWG's Plan pursues the vision and goals that reflect the collective recommendations from that body of work. BHTWG's effort differs from previous efforts in that it proposes a specific transformation structure and action, rather than once again, studying the need for transformation itself.

BHTWG reviewed and used as a foundation for their effort recommendations generated by other studies and outreach efforts. Specifically, BHTWG efforts were informed by a Western Interstate Commission for Higher Education (WICHE) study commissioned by the Idaho State Legislature, which was conducted in 2009. This report provided the basis of the vision, goals and direction the BHTWG pursued. The WICHE process included a statewide public survey, to which WICHE received the input and response of more than 550 individuals from around the state. The input of approximately 160 individuals through in-person interviews also informed the study. WICHE's outreach process is described in their report on page 43. The WICHE report can be found in its entirety at http://www.legislature.idaho.gov/sessioninfo/2008/interim/mentalhealth_WICHE.pdf. WICHE's findings and recommendations helped guide the BHTWG's work.
BHTWG reviewed and reflected on the work of other inputs and recommendations generated through previous processes. These include the 2006 Final Report of the Legislative Council Interim Committee on Mental Health and Substance Abuse; the December 15, 2006 Comprehensive Statewide Mental Health Transformation Action Plan 2007: The First Steps; annual reports of the State Mental Health Planning Council; and initiatives of the Interagency Committee on Substance Abuse Prevention and Treatment. Furthermore, BHTWG submitted an early version of their proposal to a technical panel of experts who have guided and experienced transformation, and whose advice substantively enhanced the focus and direction of BHTWGS draft. That report can be found at http://www.marshabracke.com./BHTWG.docs.htm.

The BHTWG also considered a proposal by Division of Financial Management Administrator Wayne Hammon, who responded to the Governor's request to conduct an objective assessment about how to best manage the 2011 sunset of the Interagency Committee on Substance Abuse Prevention and Treatment and the role of the Office of Drug Policy. Hammon conducted that study and generated a recommendation to the Governor, which proposes that the Director of Transformation direct the work of a Behavioral Health Transformation Office. The BHTWG recommendations are consistent with many elements of Hammon's proposal.

A special session was convened to gather the observations and insights of the judiciary. The judiciary articulated the unique characteristics of juvenile and criminal justice populations with behavioral health needs, requiring the specialized competence of providers and communication, transition and planning across behavioral health, criminal justice and juvenile justice systems.

BHTWG communicated with state legislators and Regional Mental Health Board and Resource Advisory Council chairs and members. BHTWG meetings included the participation by a range of stakeholders who provided input inside and outside the meeting setting. BHTWG conducted a statewide stakeholder, public and consumer-specific outreach process. This process featured the presentation of the BHTWG recommended structure directly to approximately 400 people, whose concerns, suggestions and sentiments were collected and reviewed. The Stakeholder, Family and Consumer report contains all of this input. The results of the BHTWG outreach process have been summarized in the BHTWG Outreach Thematic Summary, and responses to those comments are documented in there as well. These materials can all be found at http://www.marshabracke.com/BHTWG.docs.htm.

All of that input influenced the development of this Plan. The BHTWG will deliver that material to the Director of Transformation and the State Behavioral Health Interagency Cooperative, as they will want to continue to examine and utilize the information provided in this process to incorporate in transformation implementation.

Assumptions on which this plan is based include the BHTWG’s intent to:

- Integrate mental health and substance use disorder systems;
- Provide for a core array of services that span prevention through recovery in each region, with a phased-in approach to develop them based on community need, regional resources and readiness and contingent upon the structure of health care reform as adopted by the State of Idaho;

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• Generate outcome-based results that are best for consumers and families;
• Leverage the state's purchasing power, ensuring that consumers and families receive the best service at a cost that reflects the best use of taxpayer dollars;
• Assure that cost sharing is a reality as the system becomes fully integrated and regionalized, and that cost shifting does not occur;
• Establish consistent statewide standards for the quality of services;
• Provide for effective data gathering, sharing and reporting processes amongst providers and agencies to ensure sound decision-making;
• Present an implementation strategy for moving toward the transformed system; and
• Ensure collaboration and cooperation across existing mental health and substance use disorder systems.

The BHTWG is pleased to present this Plan for the Transformation of Idaho's Behavioral Health System (Plan). The Plan guides the development of a "coordinated, efficient state behavioral health infrastructure with clear responsibilities, leadership authority and action." The Plan recommends a structure that streamlines and integrates existing mental health and substance abuse disorder entities and efforts into a single behavioral health system. The structure features regional empowerment, and it provides the platform to improve access, enhance quality, develop consistent service delivery standards, generate outcome-based services and data-driven decision-making – all of which will increase efficiencies and accountabilities.

Vision and Goals

Using the body of input and material generated in years prior to and during the work of the BHTWG, the following are the Vision and Goals the BHTWG seeks to achieve for the behavioral health system.

Vision

Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance use disorders systems that are coordinated, efficient, accountable and focused on recovery.

Goals

1. Increase availability of and access to quality services;
2. Establish an infrastructure with clear responsibilities and actions;
3. Create a viable regional and/or local community delivery system;
4. Efficiently use existing and future resources;
5. Increase accountability for services and funding; and
6. Seek and include input from stakeholders and consumers.
Organizational Structure

The BHTWG proposes an organizational structure which is specifically intended to integrate mental health and substance use disorder systems and services, improve access, enhance quality, create efficiencies, clarify roles and responsibilities, support the development of increasingly viable regional delivery systems, and provide for continuous consumer and family involvement, all with a goal to create a consumer-focused recovery-oriented behavioral health system.

A description of each element of the structure follows. A table that indicates the differences between the existing and the transformed structure is included in Attachment A.

Director of Transformation

Lessons learned from other states clearly show that having one individual and office with the single responsibility to champion transformation on a daily basis by coordinating, facilitating and supporting the generation of the transformed system is essential to making transformation a reality. BHTWG agrees. With the variety of agency interests and requirements associated with behavioral health needs, and the unique and important interests and functions of the regions and their Regional Boards, the BHTWG recognizes the important role of one individual with the authority and capacity to make transformation a reality.

The Director of Transformation as proposed by the BHTWG will be the one official in the state designated to oversee and execute the coordination of the transformation of Idaho's existing mental health and substance use disorder systems into a single, effective, recovery-oriented behavioral health system. The Director of Transformation will:

- Lead the implementation of the BHTWG Transformation Plan (2010) and Behavioral Health Interagency Cooperative Transformation Implementation Plan (to be developed in 2011);
- Chair the Behavioral Health Transformation Cooperative, coordinating their respective, equitable participation in the transformation process;
- Serve as the liaison to the Regional Boards, helping to facilitate the development of a viable regional and/or local community Transformation Implementation Plans and delivery system while honoring entity and agency roles, responsibilities and accountabilities;
- Ensure that the inputs and priorities of the Regional Boards and the Cooperative are effectively used to guide the development of regional provider networks which deliver services based on regional priorities and consistent statewide standards;
- Coordinate the development of a statewide or series of contracts in a manner that reflects regional priorities, meets agency accountability and reporting requirements, reflects consistent statewide standards, and maximizes the use of the taxpayer dollar;
- Refine and focus the transformation effort over time as implementation lessons are learned, research and best practices are identified, considered and applied as appropriate, and data and performance measures inform strategic direction;
- Represent the Behavioral Health Cooperative in statewide efforts to coordinate health care reform implementation.

The individual who secures the position of Director of Transformation requires the following minimum qualifications, to include:
• Considerable knowledge of policy and procedures for all three branches of government;
• Demonstrated understanding and/or experience with government systems, judicial processes and systems change;
• Demonstrated understanding and/or experience with public health delivery system and consumer and family needs;
• Considerable knowledge of quality, outcome-based, cost effective treatment for a behavioral health system of care, including mental illness and substance use disorders;
• Demonstrated leadership skills;
• Competency in management; and
• Demonstrated ability to:
  o Hire and supervise staff,
  o Interpret and apply laws, rules and regulations,
  o Develop and implement new policy and procedures,
  o Facilitate, coordinate and communicate effectively with diverse groups of stakeholders and the public,
  o Support contractual and fiscal responsibilities,
  o Manage complex projects, and
  o Solve problems.

Subject to available funding, the Director shall have the authority to hire staff to assist in the performance of the Director's responsibility. Each member of the Statewide Behavioral Health Interagency Cooperative will support transformation by using existing staff to work in coordination with the transformation effort.

BHTWG has produced a job description for the Director of Transformation that reflects these responsibilities and qualifications. This document is included as Attachment B.

**BHTWG Recommendation:**

*BHTWG recommends that legislation be drafted for and presented to the 2011 of the Idaho State Legislature that establishes the Behavioral Health Transformation Office (BHTO) and the position of Director of Transformation to direct that office in a manner consistent with the roles and responsibilities outlined in the Director of Transformation job description (included as Attachment B). The Director of Transformation is specifically intended to act as a daily and continuous champion for the transformation effort on a local, regional and state level.*

*Furthermore, BHTWG recommends that the BHTWG, Cooperative, and Interagency Committee on Substance Abuse Prevention and Treatment forward the names of prospective candidates who meet the requirements of the position for appointment by the Governor.*

*The BHTO and the Director of Transformation function are recommended for review in 2016, with a potential sunset or continuation of the Office and position depending on the outcome of that review.*
Regional Behavioral Health Community Development Boards

Creating a viable regional behavioral health delivery system is a specific transformation goal. It is imperative that the delivery system be locally accessible and effectively meet consumer and family needs. Coordination of that delivery system and building the capacity to support it is a critically important function. BHTWG recommends a regionally based system that is responsive to regional needs and is driven by regional leadership.

BHTWG proposes integrating the existing Regional Mental Health Boards and Regional Advisory Councils function. Regional Behavioral Health Community Development Boards (Regional Boards) would be formed to enable regions to focus on behavioral health needs, capacity and services in the region. The Regional Boards will:

- Feature a small and efficiently organized management team which capitalizes on robust subcommittee efforts to inform their work, specifically including a consumer and family subcommittee and a provider subcommittee;
- Develop a regionally focused Transformation Implementation Plan that specifically describes the region's goals, objectives, strategies and progress toward making available the array of core services (that span prevention through recovery) to be approved by the Cooperative;
- Be knowledgeable about the amount and intended use of the collective resources available to the region, knowing that the process would start using a braided funding approach;
- Address regional issues associated with workforce capacity and development;
- Have the ability to pursue funding and do contracting;
- Deliver an annual update of the Transformation Implementation Plan and report on its progress to the Director of Transformation and the Cooperative;
- Have a representative serve on the State Behavioral Health Planning Council;
- Identify regional priorities and inform Regional Provider Network contract development and evaluation processes in coordination with the Director of Transformation; and
- Demonstrate readiness for contracting for behavioral health services according to criteria established by the Cooperative.

Membership proposed for the Regional Boards include representatives from:

- Counties,
- Law Enforcement,
- Courts,
- Schools,
- Two professionals from the Provider Network/Provider Subcommittee which may be a psychiatrist or physician and a behavioral health care professional, ensuring both mental health and substance use disorder services are represented,
- Public Health Districts,
- Consumer and Family Subcommittee, and
- Regionally based agency representation from IDOC, IDJC and DHW.

While most participants on the Regional Boards are anticipated to be volunteers who serve because behavioral health is related to their work, a responsibility they have to their clients, or an important aspect of their lives, the BHTWG recognizes that, with this focused responsibility, support staff for the
Regional Boards is critically important. The issue of resources is one that the BHTWG acknowledges and discusses later in this report.

**BHTWG Recommendation:**

BHTWG recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislature, in anticipation that Regional Behavioral Health Community Development Boards be established and populated during 2011 and functional by December 2011. The establishment of Regional Behavioral Health Community Development Boards eliminates the need for the existing Regional Mental Health Advisory Boards and the Regional Advisory Councils.

**State Behavioral Health Planning Council**

The purpose of the existing State Mental Health Planning Council is to review the State Mental Health Systems Plan, serve as an advocate for adults and children, and to evaluate on an annual basis the allocation and adequacy of mental health services within the state (Idaho Code 29-3125). The Council’s work is key to securing the Community Block Grant which helps fund these services, as described in U.S. Code (Title 42, Chapter 6A, Subchapter XVII, Part B-Block Grants Regarding Mental Health and Substance abuse, subpart i).

The BHTWG proposes that the Planning Council’s membership be consistent with that required by federal law as follows:

(c) Membership

(1) In general

A condition under subsection (a) of this section for a Council is that the Council be composed of residents of the State, including representatives of—

(A) The principal State agencies with respect to—

(i) Mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) The development of the plan submitted pursuant to title XIX of the Social Security Act [42 U.S.C. 1396 et seq.];

(B) Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) Adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) The families of such adults or families of children with emotional disturbance.

(2) Certain requirements

A condition under subsection (a) of this section for a Council is that—

(A) With respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) Not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Within that configuration, BHTWG recommends that membership on the Council:
• Include comparable representation from individuals bringing substance use disorder and suicide prevention expertise and experience to the Council in order to facilitate the integration of the mental health and substance use disorder systems;
• Include one representative from each of the seven Regional Boards to secure representation by the Boards at a state level and facilitate the development of a seamless behavioral health system statewide;
• Include the ex officio participation of members from both the House and Senate Health and Welfare Committees and a member of the Judiciary branches of government;
• Include one specific seat for a representative from an advocacy organization; and
• To ensure efficiency and effectiveness, work to limit the total number of members on the Council and generate subcommittee or ex officio involvement as needed to secure the representative participation needs of the Council at any given point in time.

**BHTWG Recommendation**

*BHTWG recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislature in order to modify the role of the State Mental Health Planning Council to one that has a behavioral health focus and is called the State Behavioral Health Planning Council, fulfills the requirements of federal law, includes representation from each of the Regional Boards, and limits the group's membership to a representative but efficient number.*

**Statewide Behavioral Health Interagency Cooperative**

A number of agencies are legislatively funded to provide or authorized to order behavioral health services for consumers and families. Clearly the Department of Health and Welfare has the greatest portion of that budget and responsibility, including Medicaid. Other agencies and counties also have funding and important responsibilities for providing services. For example, counties support indigent clients; the Idaho Department of Juvenile Corrections, in partnership with counties, has funding to appropriately serve juveniles with mental health needs in the community; schools work to find services for students with behavioral health needs; and the Idaho Department of Correction works to transition offenders from IDOC facilities back to the community. The Courts order assessments and services provided by the Department of Health and Welfare.

In order to generate an effective system that is truly client-focused and maximizes the use taxpayer dollars, these agencies must partner to ensure that monies are being best spent, and that clients needs are most effectively met, across systems. Working together, these purchasers and users of services can enhance the system in a manner that generates more effective results. Braided funding (see Attachment C for a description of braided funding and its advantages), shared data and information, coordinated contracting, consistent standards – all are opportunities for the agencies to better serve the client and get the best use of limited resources.

To that end, the Statewide Behavioral Health Interagency Cooperative is to be a small, action-oriented group comprised of government entities that are purchasers and users of services. A representative from the State Behavioral Health Planning Council would sit on the Council to advocate for consumers and families in this forum.
Each Member of the Cooperative would assume shared responsibility to achieve transformation. The Cooperative will:

- Work in coordination with local and state government, the judiciary, and specifically with the Office of the Governor and members of the Senate and House Committees on Health and Welfare;
- Provide input to draft legislation regarding transformation of the behavioral health system as it is under development and worked through the legislative process;
- Review and confirm recommendations, statewide standards, guidelines, contract templates, core services, and other elements of the behavioral health system as they are developed by respective entities;
- Ensure the implementation of the transformation effort as described in the BHTWG Plan for Transformation of Idaho’s Behavioral Health System (October 2010), by providing for efficient and effective interagency coordination of systems, operations, services, and funding;
- Produce and present a status report of their interagency efforts and accomplishments to the Office of the Governor, the Chief Justice of the Idaho Supreme Court, counties, and members of the Senate and House Committees on Health and Welfare on an annual basis; and
- Develop, annually update and commit to implementing a Transformation Implementation Plan that is equally applicable to all entities involved with the Cooperative. The Transformation Implementation Plan will address:
  - Overall policies, strategies, steps, and timelines related to transformation implementation
  - Strategies for coordination, cooperation, collaboration, forging partnerships and understandings between behavioral health, education and justice systems;
  - Agreement on the agency staff responsible for specific duties related to the transformation and operation of the behavioral health system as well as a system to ensure accountability to the plan;
  - Statewide behavioral health needs and gaps;
  - A braided funding strategy which coordinates budgets, establishes priorities and addresses issues of funding availability;
  - Data and information sharing, reports and functionality;
  - Coordinated approaches for the delivery of behavioral health services and the elimination of duplicative services among relevant agencies;
  - Readiness criteria for regional contracting;
  - Workforce development and training for public and private providers, including multidisciplinary approaches;
  - Best practices;
  - Ongoing communication strategies;
  - System performance and evaluation and outcome-based performance measures; and
  - The role of behavioral health in Health Care Reform.

The Cooperative will:

- Identify and forward prospective candidates for the position of Director of Transformation;
- Collect and share data needs and requirements and propose how data can be effectively coordinated/cross-walked across agencies;
- Quantify total state funding across entities so that regions and the state can plan for the most effective use of taxpayer dollars;
• Share funding information on a regional scale with regional boards so that they can provide informed input about their needs and priorities;
• Participate in a braided funding scenario where funding streams from various sources are coordinated to support a broad continuum of behavioral health services;
• Articulate their respective needs and requirements for use in Regional Provider Network contracting and evaluation processes;
• Confirm a shared understanding of service standards developed by DHW, which operates as the State Behavioral Health Authority and who will monitor for performance based on consistent service standards statewide; and
• Purchase services through the Regional Provider Networks through contractual arrangement(s) which articulate shared service standards, collects and shares system-wide data, meets reporting requirements of state and federal funding entities, provides for the best use of the taxpayer dollar, and secures the best outcomes for the family and consumer.

Members of the Cooperative shall be appointed by and serve at the pleasure of the Governor, and are proposed to include the:

• Director, Department of Health and Welfare;
• Director, Department of Correction;
• Director, Department of Juvenile Corrections;
• Superintendent of Public Instruction;
• Administrative Director of Idaho Courts;
• One representative from among the Counties;
• One representative from the State Planning Council.

The Cooperative will meet monthly or more frequently as necessary to achieve its goals. The Director of Transformation, with responsibilities as described in this Plan, will chair the Cooperative. A draft Executive Order to establish the Cooperative is included as Attachment D.

**BHTWG Recommendation:**

_BHTWG recommends that the Governor’s Office issue an Executive Order to activate the Statewide Behavioral Health Cooperative and its responsibilities in response to the delivery of this Plan._

_This action ensures that the momentum generated by the BHTWG and the completion of specific activities as proposed in this Plan are accomplished. These activities include identifying prospective candidates as the Director of Transformation, reviewing and supporting draft legislation to implement the transformation structure, and serving as a point of contact and information for regional stakeholders until that time the Director of Transformation is secured. The Executive Order is recommended to require a review of the need for the Cooperative again in 2016, with a potential sunset or continuation of the Cooperative depending on the outcome of that review._

_BHTWG also recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislation to legislatively enact the Cooperative as described by the Executive Order concurrently with the sunset of ICSA in June._
State Behavioral Health Authority

Increasing quality and accountability are two transformation goals specifically addressed through the establishment of a State Behavioral Health Authority (Authority). As the designated Authority, the Idaho Department of Health and Welfare will:

- Develop and confirm statewide service and delivery standards;
- Integrate standards into Regional Provider Network contract(s) requirements;
- Monitor the performance measures/outcomes outlined in the contracted arrangement;
- Generate and implement a provider certification process (including appropriate workforce credentials and requirements);
- Explore and if possible secure a Medicaid Waiver;
- Continue to enhance the data reporting process to support transformation objectives;
- Step in and provide regional leadership on behalf of the Regional Boards should a Board find itself unable to function (but not in place of providers of services); and
- Facilitate the data reporting process to enable informed regional planning and input processes which can be used to generate continuous improvement to the system.

The State Behavioral Health Authority will measure the effectiveness of the behavioral health service delivery system in coordination with members of the Cooperative by examining quality of life measures, criminogenic need assessments, as well as other standardized outcome based instruments as determined by the Authority and confirmed by the Cooperative.

Ultimately, the Authority function provides for accountability and quality assurance respective to the delivery of services according to the standards and performance measures generated and applied to those services.

**BHTWG Recommendation:**

*BHTWG recommends that the Idaho Department of Health and Welfare continue to function as the State Behavioral Health Authority, and to coordinate and communicate the status of that effort and scope as described in this Plan within the context of the Cooperative.*

Regional Provider Networks

Providers are essential to delivering services to consumers and families. The existing system relies on providers from throughout the state; the transformed system will do the same. The transformed system will create an opportunity for a level of service delivery that doesn't currently exist. The establishment of statewide standards of care provides the professional providers who maintain a certain level of quality and higher to be featured within the system. All purchasers and users of this system will know that each service achieves a specific standard which is consistently provided by any provider throughout the state. Under a contractual arrangement, many providers can be available to serve the range of clients to whom the state provides benefits. Within this structure, providers will have the initiative and incentive to maximize the use of community based services, deliberately move clients toward recovery, and document the practices and the measurements that got them there. Providers have a critically important role in ensuring that a client-focused delivery system exists, regardless of which agency is paying the bill, or in which region of the state the client lives.
The BHTWG acknowledges that currently there are shortages of mental health and substance use disorder providers statewide. In a transformed, integrated behavioral health system, additional providers will be needed. These providers may need additional education and certifications in order to provide services that meet contractual requirements. As these standards are developed and implemented, higher education institutions must be responsive to these workforce demands.

The structure proposed by the BHTWG is designed to support the development and implementation of Regional Provider Networks. These Networks are anticipated to be comprised of a grouping or groupings of private providers within a region that gather contractually with a commitment to serve the client-focused needs of the region and meet statewide standards for service delivery. Given the braided funding scenario by which the payers will be operating, the Regional Networks will bill and the payers will pay using consistent contract vehicle(s).

It is anticipated that the Regional Networks will:

- Supply a significant number of the services identified in the array of the core services proposed for the system;
- Provide recovery-focused, evidence-based based services with contractually required outcome reporting;
- Be a community partner, working to foster a strong and responsive community based resource;
- Have a medical professional representative participate on the Regional Board;
- Be incentivized to provide quality community-based care; and
- Meet the requirements of the contract under which the Regional Provider Networks are authorized and formed.

Given that 1) statewide standards are just in initial stages of development, 2) the standards and regional and payer priorities are to be reflected in the eventual contract, and 3) the complexity of any given contracting process, realizing a regionally organized and based service delivery system will take time. Doing so will require the involvement and input of the Regional Boards and Cooperative in coordination with the Director of Transformation as well as the provider community.

**BHTWG Recommendation:**

*BHTWG recommends that the structure proposed to be established via Executive Order in 2010 and Legislation in 2011 be so established, tasking that structure with the continued development of transformation and the associated standards, data, need, priorities and funding coordination that will further inform the development of a delivery system featuring Regional Provider Networks.*

**Array of Core Services**

To ensure a meaningful and efficient system of care in the State of Idaho, an array of behavioral health services that span prevention to recovery must be available on as local a level as possible.

In this plan, *core services* are defined as an array of services including those that are community based, emergent, medically necessary, and required by law. They provide a “floor” of services intended to be developed and available in each region that span prevention, intervention, treatment and recovery.
With transformation, the goal is to redirect supports from the more expensive emergent and medically necessary services to more effective and less costly prevention, intervention and recovery services.

In this context, core services will be provided in accordance with statewide standards which will include, at minimum, monitoring for quality, consistency and effectiveness. These services will be delivered from a client-centered perspective. Effectiveness of service delivery will be determined by examining quality of life measures as well as other standardized outcome-based instruments. The core services will be provided for in a way that:

- Is outcome oriented;
- Features accessibility on as local a level possible;
- Is integrated and coordinated across responsible agencies and entities;
- Distinguishes between, accommodates the differences, and meaningfully supports the child, the adult, and the transition between them;
- Recognizes the importance of family involvement and utilization of natural support systems; and
- Fosters the involvement of qualified and experienced psychiatric care providers or psychiatrists.

The array of core services are described generically; specific programs or methods for delivering the service are not defined. The intent is to identify the fundamental focus of the service and to provide flexibility in delivery mechanisms.

Clearly the development of an array of core services in each region will take time. Providing a range of services that exceed the array of core services proposed here is a welcome initiative. During transformation, there are a number of considerations to be taken into account. Specifically:

- Each region features a different mix of professional expertise and community volunteerism - the array of services might be achieved through different venues or have a different configuration from one region to another;
- Core services are intended to be available in all regions, but the prevalence of any core service may vary among regions as appropriate to reflect the needs of a region's targeted populations;
- Regions will develop local access standards using their own demographics, geography and availability of services within pocketed areas of their region;
- Some regions might look to their neighboring regions to help make a service available that is not available in their own;
- The goal is for regions to be able to deliver this array of services without depending upon the state to provide the same services;
- Regions have the authority and flexibility to build their service delivery systems in good faith, making reasonable attempts to make all core services available;
- It is intended that regions be poised to succeed in ultimately delivering the complete array of core services;
- This array of core services is intended to provide a consistent "floor" of services for individuals throughout Idaho -- regions may opt to provide an array of services that exceed those proposed here, and that such an initiative is desirable;
- The development of the regional system will occur in a transitional manner, potentially learning from the experience of a pilot region and/or by a phased-in approach to making the array of services available; and
- Some services currently provided by the state may be phased into regional responsibility.
Recognizing that 1) there may be an inclination to provide emergent and medically necessary services as a priority over other services, and 2) the delivery of preventative and community-based services can in some cases be provided at relatively low cost and more effectively enhance an individual’s quality of life, it is the specific intent of transformation to emphasize prevention, intervention and recovery services in regional systems.

Core services are to be targeted to citizens of the state of Idaho on a sliding fee scale basis (to be determined) and will include adults and children with mental health and substance use disorders.

Definitions of each of the core services identified in the table below are included as Attachment E. The array of core services may evolve over time. This list will be managed by the Cooperative; Transformation Implementation Plans produced on the state and regional level will be designed with the goal to develop the services.

**BHTWG Recommendation:**

BHTWG recommends that the regions and the state adopt this array of core services as the “floor” of services they seek to make available in each region, that this array be maintained as the goal for regional planning and capacity building, and that it also be used as a measure by which to indicate progress toward a truly transformed behavioral health system over the long term.

<table>
<thead>
<tr>
<th>No.</th>
<th>Core Service</th>
<th>Emergent</th>
<th>Medically Necessary</th>
<th>Structurally Necessary (non-institutional)</th>
<th>Medicaid Covered</th>
<th>Substance Use</th>
<th>Mental Health</th>
<th>Adult</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Assertive Community Treatment (ACT), Intensive Case Management Services and Wraparound</td>
<td>X</td>
<td>X</td>
<td>+/-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2.</td>
<td>Assessments and Evaluations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>+/-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3.</td>
<td>Case Management Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4.</td>
<td>Designated Examinations and Dispositions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5.</td>
<td>Intensive Outpatient Treatment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>+/-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>6.</td>
<td>Illness Self-Management and Recovery Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>7.</td>
<td>Inpatient Psychiatric Hospitalization</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>8.</td>
<td>Medication Management</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>9.</td>
<td>Drug Screening</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10.</td>
<td>Peer Support Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>11.</td>
<td>Prevention Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>12.</td>
<td>Early Intervention Services for Children and Adolescents</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>13.</td>
<td>Psychiatric Emergency and Crisis Intervention services (24/7 with open door access)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>+/-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>14.</td>
<td>Psychotherapy (including trauma-informed care and cognitive behavioral therapy)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>15.</td>
<td>Alcohol and Drug Residential Treatment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>16.</td>
<td>Supported employment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>17.</td>
<td>Supported housing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>18.</td>
<td>Transformation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>19.</td>
<td>24-Hour Out-Of-Home Treatment Interventions For Children And Adolescents</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>20.</td>
<td>Day Treatment, Partial Care and Partial Hospitalization</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Table 1: Core Services**
Funding and Resources

The reality is that funding and resources are limited. The economic situation has forced the closure of several Department of Health and Welfare offices. Medicaid dollars are likely to become tighter in this economic climate and as other agencies and counties face budget cuts and challenges meeting the demand for mental health and substance use disorder treatment. With the shrinking pool of dollars, Idaho has already, unfortunately, seen an increased use of high cost crisis services and cost-shifting – a situation unlikely to change as this economic downturn lingers. The BHTWG’s intent is to assure that cost sharing is a reality and as the system becomes fully integrated and regionalized, that cost shifting does not occur.

Without change, the existing situation will get even worse.

The BHTWG has been asked how it can propose to transform a system that the state already cannot afford. Regional stakeholders, regardless of how eager they may or may not be to assume a leadership role for their regional delivery system, wonder how they can resource the effort it will take to identify needs, generate a regionally focused transformation implementation plan, build workforce capacity, and secure community supports. Agencies participating on the BHTWG ask themselves the same question – with the existing budget realities how do they generate new responsibilities, help support the efforts of the Behavioral Health Transformation Office, or divert resources without cutting already pared services? The situation is further complicated by the lack of providers in rural areas and a disinclination of many providers to support Medicare and Medicaid clients.

The reality is that the impetus for transforming the behavioral health system has been underway for years. Many groups have proposed a transformed system. The fact that BHTWG has been asked to develop a plan to achieve it at a time when DHW has had to close some of its offices is coincidental, unfortunate, and unrelated. However, DHW and other entities that fund behavioral health services are working to ensure whatever adjustments they make because of the economy line up as much as possible with a structure consistent with a transformed environment. By using the lack of resources as a reason to make no change, the existing situation will get predictably worse; higher cost crisis services will become the stop gap for escalating issues avoided by the availability of early intervention and prevention services.

Stakeholders, consumers and families have made suggestions for how to resource transformation. Some of these include reassigning existing state staff, generating a tax on beer and wine, and legislating additional funding. Whether any of these are possible remains a question.

BHTWG has spent time collecting and discussing the dollars spent on mental health and substance use disorders services and systems across the state. This effort has generated an understanding of what is collectively spent; but what is spent on behavioral health does not answer important questions: What is the actual need? And what is the cost of that need?

To answer these questions, and to use what funding the state does have most effectively, there is much more work to do. It will be incumbent upon the Behavioral Health Interagency Cooperative to continue to explore how to best leverage the taxpayer dollar to get the most appropriate services to consumers and families at the most appropriate time, location and cost. BHTWG is committed, even in these
economic times, to work to create the most effective client-focused system it can now, and position itself for an increasingly accessible and effective system in the future.

Idaho's experience indicates how cooperating to meet needs can generate more effective services and cost savings. For example:

**Detention Clinician Project**
The Detention Clinician Project authorized by the Idaho Legislature in 2008 continues as a partnership among DHW, counties and the Idaho Department of Juvenile Corrections (IDJC), using state funds to place a clinician in each of the twelve juvenile detention centers around the state. Some of the findings from a research study completed by Dr. Ted McDonald of Boise State University reveal the following:

- Three out of four juveniles (75%) entering detention facilities have a mental health issue and/or substance use disorder;
- Over half of the juveniles who are recommended for community-based mental health and/or substance use disorder services after an evaluation by a detention clinician accessed those services within 15-30 days post release;
- Eighty-five percent (85%) of probation officers and judges reported that information from the clinician had an impact on case disposition and service planning;
- One hundred percent (100%) of judges and probation officers indicated a strong desire to see the clinician program continue; and
- Nearly seventy-five percent (75%) of parents reported that their child had received at least one of the services recommended by the clinician.

Data collected by IDJC during juvenile detention facility inspections reveals a drop in critical incidents as well as admissions. During a presentation of this report on February 2, 2010, Juvenile Detention Administrators credited the drop in incidents and admissions to the presence of clinicians in the facilities. They also reported increased morale, confidence, and competence of facility staff due to the training and support provided by clinicians.

**Contracting Initiatives**
IDJC funds a program to support the community based treatment of juveniles at risk of commitment and for those leaving a period of commitment. One of the evidence-based services offered within this program is Functional Family Therapy (FFT). Rates of reimbursement for FFT services varied depending upon the overall level of service indicated in the service plan and were in many cases different. IDJC was able to achieve the same cost of FFT services to the common rate paid by IDHW.

**Reductions in Community Hospitalization Costs**
Home Recovery Team (HRT) is an innovative public-private partnership that was formed in DHW Region 4 in February 2009. This team focused on the provision of community supports as an alternative to hospitalization for those in crisis, with services provided by a combined HRT staff mix of two professionals and two Certified Peer Specialists. At a cost of approximately $200,000 per year, the Home Recovery Team (HRT) provided short-term (i.e., 7-14 days) intervention, daily in-home support and treatment for at risk individuals. The savings from diverted hospitalizations in the first year of HRT operation was
approximately $600,000. Despite the success of the HRT pilot, this project was discontinued in May 2010 because of budget cuts.

In addition to the reduction in hospitalization realized through the HRT, the Division of Behavioral Health also implemented a new process for admissions and discharges to the state hospitals. The new process established a protocol to identify the coordination of regional and hospital responsibilities for the admission and discharge processes. Through the creation of the new policy, the Department saved an estimated 1.2 million dollars in Community Hospitalization funds over the previous fiscal year.

To start, the structure proposed by the BHTWG offers some opportunity for transformation in a cost-neutral manner. As proposed, the Behavioral Health Transformation Office and the Director of Transformation can be funded by a redirection of funds currently supporting the Office of Drug Policy. Funds are not available for additional staffing of that office, but efforts to identify and secure grant funding to support transformation are underway, and coordination of existing resources within state agencies through the Cooperative might be found to support transformation activities.

Currently two sets of regional bodies work to address mental health and substance use disorders in each of the regions. The structure proposed by the BHTWG streamlines that effort by integrating the two and forming one, smaller, action-oriented body to work on behalf of the regions utilizing an intentional subcommittee effort to inform their activities. Regional Board members are anticipated to be volunteers whose participation is directly relevant to their work. Still, the BHTWG recognizes that support staff to help the Regional Boards is a necessity with its new responsibilities and accountabilities, and that specific funding to provide that support is not available. In coordination with the Director of Transformation, regions may be able to secure grant funding to help support such a position. Participants in the system can continue to study how to resource this function.

Early intervention and prevention efforts and community supports are less expensive and more positive services than crisis, hospitalization and incarceration. As regional capacity grows, the ability to emphasize these services over the more expensive options will begin to generate a savings in the cost of supporting individual needs and reduce cost-shifting. With the eventual implementation of outcomes-based measurements and monitoring, adjustments can be made to the services and the system to maximize the results for the client and the taxpayer.

The braided funding scenario also provides an opportunity for funding agencies to leverage their resources. With a contractual arrangement that enables all payers of services to purchase services that are consistently delivered at a known cost, the payers achieve purchasing power at a level that doesn’t currently exist.

Key to any cost-savings to be achieved by the transformed system, however, now or in the future, is the commitment that all monies saved will be reinvested in the system rather than redirected for other uses. Only through that reinvestment can the gains achieved by the more effective system become increasingly helpful to serving consumers and families, and can the system sustain its decreasing reliance on high cost services.

BHTWG recognizes that Medicaid is a primary funder of this system. With Health Care Reform Idaho is likely to see a greater number of individuals on Medicaid. By taking deliberate action now, Idaho can position itself to support an increased number of clients and benefits throughout the state.
Health Care Reform will also perpetuate the movement to integrate mental health and substance use disorders with physical health. Today's movement to a behavioral health system in Idaho is a first important step toward what is anticipated to be a truly integrated health system in years to come. It is important for Idaho to plan for this eventuality, and to look strategically toward an integration that continues a client-centered and effective system.

Clearly, with adequate resources the structural components described here could mobilize the envisioned system much more quickly than they will be able to without those resources. The issue of resources is one with which the state and the regions will continue to grapple. Still, BHTWG recommends that the state position itself to support consumer and family service needs in the most efficient and effective manner. The structure proposed here puts that action in motion and empowers the regions to begin to generate their strategy and capacity for when increased funding is a reality.

The financial support for behavioral health services in the braided funding environment shall be provided by state appropriations for mental health and substance use disorder funding for the entities on the Cooperative, county mental health funding, client co-payments and insurance, federal funding, and by whatever grant funding is secured by the regions or the state.
Attachment A: Structure Table

BHTWG’s Plan guides the development of a "coordinated, efficient state behavioral health infrastructure with clear responsibilities, leadership authority and action." It establishes a specific structure for generating the transformed system it describes, and it puts in motion the process for developing that system over time.

The structure enables individuals involved on a local, regional and state level to continue to contribute more concrete thinking and action to transformation.

Differences between the existing and proposed structure, with action steps to get there, are reflected on the table below.

<table>
<thead>
<tr>
<th>Element</th>
<th>Existing</th>
<th>Recommended</th>
<th>Action Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems</td>
<td>• Substance use disorders</td>
<td>• Behavioral Health</td>
<td>Generate an integrated structure which can then pursue behavioral health work</td>
</tr>
<tr>
<td></td>
<td>• Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td>• Siloed</td>
<td>• Braided</td>
<td>Develop a plan to integrate funding streams and begin to position funders to pay the same amount for the same service with consistent standards.</td>
</tr>
<tr>
<td>Regional Leadership</td>
<td>• Regional Advisory Councils (substance use disorders only)</td>
<td>• Regional Behavioral Health Community Development Boards</td>
<td>Pursue legislation in 2011 to develop Regional Behavioral Health Community Development Boards.</td>
</tr>
<tr>
<td></td>
<td>• Regional Mental Health Boards (mental health only)</td>
<td>• Robust Subcommittee involvement (specifically including Consumers and Families)</td>
<td></td>
</tr>
<tr>
<td>State Level Coordination</td>
<td>• State Mental Health Planning Council (mental health only)</td>
<td>• State Behavioral Health Planning Council</td>
<td>Pursue legislation in 2011 to develop the Statewide Behavioral Health Planning Council.</td>
</tr>
<tr>
<td></td>
<td>• Interagency Committee on Substance Abuse and Treatment Prevention (substance use disorders only)</td>
<td>• Statewide Behavioral Health Cooperative</td>
<td>With the delivery of this plan (October 2010), issue an Executive Order to establish the Statewide Behavioral Health Cooperative to coordinate the operational elements of transformation. To be followed by legislation in 2011.</td>
</tr>
<tr>
<td></td>
<td>• Department of Health and Welfare</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Idaho Department of Juvenile Corrections</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Idaho Department of Correction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• State Department of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Office of Drug Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Courts</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Counties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Transformation</td>
<td>• No single point of leadership for the coordination and delivery of services</td>
<td>• Director of Transformation – a cabinet level professional responsible for oversight of the transformation</td>
<td>Pursue legislation in 2011 to establish the position of the Director of Transformation describing roles, responsibilities, accountabilities.</td>
</tr>
<tr>
<td>Data</td>
<td>• Insufficient and disparate data collection</td>
<td>• Standardized data collection with common core measures across systems</td>
<td>Identify core measures and integrate into new and existing data collection methods</td>
</tr>
</tbody>
</table>
Attachment B:
Director of Transformation Job Description

DIRECTOR OF TRANSFORMATION

PRINCIPLE ACCOUNTABILITIES

The Director of Transformation is the state official designated to oversee and execute the coordination of the transformation of Idaho’s existing mental health and substance use disorder systems into a single, effective, outcome-based and recovery-oriented behavioral health system. The behavioral health system is intended to be one where Idaho citizens and their families have appropriate access to quality services provided through a system that is coordinated, efficient, accountable, and focused on recovery.

The Director of Transformation directs the efforts of the Behavioral Health Transformation Office. The Director of Transformation champions the transformation effort, and has the daily responsibility and accountability for achieving the transformed system working in coordination with the Interagency Behavioral Health Transformation Cooperative. The Director of Transformation will:

- Lead the implementation of the BHTWG Transformation Plan (2010) and Behavioral Health Interagency Cooperative Transformation Implementation Plan (to be developed in 2011);
- Chair of the Behavioral Health Transformation Cooperative, coordinating their respective, equitable participation in the transformation process;
- Serve as the liaison to the Regional Boards, helping to facilitate the development of a viable regional and/or local community Transformation Implementation Plans and delivery system while honoring entity and agency roles, responsibilities and accountabilities;
- Ensure that the inputs and priorities of the Regional Boards and the Cooperative are effectively used to guide the development of regional provider networks which deliver services based on regional priorities and consistent statewide standards;
- Coordinate the development of a statewide or series of contracts in a manner that reflects regional priorities, meets agency accountability and reporting requirements, reflects consistent statewide standards, and maximizes the use of the taxpayer dollar;
- Refine and focus the transformation effort over time as implementation lessons are learned, research and best practices are identified, considered and applied as appropriate, and data and performance measures inform strategic direction; and
- Represent the Behavioral Health Cooperative in statewide efforts to coordinate health care reform implementation.

MINIMUM QUALIFICATIONS

The individual who secures the position of Director of Transformation would require the following minimum qualifications, to include:

- Considerable knowledge of policy and procedures for all branches of state and local government;
- Demonstrated understanding and/or experience with government systems, judicial processes, and experience with systems change;
• Demonstrated understanding and/or experience with public health delivery system and consumer and family needs;

• Considerable knowledge of quality, outcome-based, cost effective treatment for a behavioral health system of care and providing for adults and children with mental health and substance abuse disorders;

• Demonstrated leadership skills;

• Competency in management; and

• Demonstrated ability to:
  o Hire and supervise staff,
  o Interpret and apply laws, rules and regulations,
  o Develop and implement new policy and procedures,
  o Facilitate, coordinate and communicate effectively with diverse groups of stakeholders and the public,
  o Support contractual and fiscal responsibilities,
  o Manage complex projects, and
  o Solve problems.
treatment needs, providers, and State public mental health system design and financing has focused on experiences in a small number of States. Given the inherent differences of State Medicaid and mental health delivery systems, the findings of these studies are not easily generalizable. Additional research in both the private and public sectors is needed to better inform purchasers about the relative effects of different risk-sharing approaches to make choices about system design and purchasing decisions.

II. Blending and Braiding Funding Streams in Managed Mental Health Care

Question: Should funding streams from multiple public and private sector payors of managed mental health care services be combined? If so, is blending or braiding a better way to combine these funding streams, and what are the requirements for their long-term success?

Answer: Yes. Several evaluations (largely based on expert opinion) of systems that use multiple funding sources have found that respondents believe that combining multiple funding streams across service sectors using blending or braiding techniques is a desirable way to overcome fragmented multiple mental health treatment systems. Further, respondents believe that braiding funds, rather than blending them, allows better tracking and accountability for each agency’s financial and programmatic contributions. Combining funding in these ways enhances flexibility to provide access to a coordinated array of mental health, medical, and social services that result in better outcomes. Successful approaches are characterized by involving stakeholders early in the planning process, obtaining leadership commitment, and implementing ongoing monitoring systems for financial and outcomes accountability.

1. Definitions of “Blending” and “Braiding” Funding Streams

Although the goals of both blending and braiding funding streams are essentially the same, the two are different in the manner in which they are structured and managed.

With blended funding streams, funds from multiple sources (e.g., Medicaid, mental health, child welfare, and education) are combined into a single pool that is used to pay providers. Essentially, blended funding combines funds at the “front end” by first combining funds from multiple sources into a single pool. An often-cited example of a blended funding approach is Wraparound Milwaukee in Milwaukee County, Wisconsin.19

With braided funding streams, the funds from various sources are not pooled into a single account; rather, a separate administrative entity such as a fiscal agent monitors and tracks the relative distribution of the levels of each participating agency’s responsibility for treatment service delivery and then authorizes payment to providers. Thus, braided funding combines funds at the “back end,” when payments to providers are made (Flynn & Hayes, 2003; Koyanagi, 2003a; Koyanagi, 2003b). An often-cited example of a braided funding approach is the Dawn Project in Marion County, Indiana20 (Koyanagi, 2003a; Pires, 2002).

2. Rationales for Blending or Braiding Funding Streams

There are many Federal, State, local, and private sector funding streams that have been developed over the years that include resources for paying for mental health treatment services. Each funding source has its
own requirements for which services are provided and who is eligible to provide and receive them. In addition to private sector health insurance, public sector examples include Medicaid, SCHIP, Temporary Assistance for Needy Families (TANF), child welfare, juvenile justice, education, social services, maternal and child health, and State and local mental health programs, each of which is governed by different statutory and regulatory requirements (Burns, Costello, Angold, & Tweed, 1995; Hodges, Nesman, & Hernandez, 1998; Koyanagi, 2003b; Pires, 2002).

One of the effects of these multiple sources of funding has been the development of a generally fragmented service delivery system. This system is often confusing and difficult to navigate for children with mental health care needs and their families. There is widespread recognition that the successful treatment of SEDs among children and adolescents requires access to comprehensive, integrated, and coordinated community-based services that include not only mental health care services, but also medical and social support services (Haison, Deere, Lee, Lewin, & Seval, 2001; Koppelman, 2004; Seltzer, 2003; Stroul, Pires, Armstrong, & Zaro, 2002).

Beginning in the late 1980s, States and localities developed holistic approaches to creating more seamless delivery systems that are founded on a “system of care” concept. This concept emphasizes availability of an array of services, individualized care, services provided in the least restrictive environment, full participation of families, coordination among child-serving agencies and programs, and cultural competence (Stroul, 2002; SAMHSA, 2005).

The financial boundaries and requirements of the many available funding sources must be “bridged” to provide for their most effective and efficient use. The use of blended or braided financing mechanisms represents a way to bridge these boundaries by providing centralized points of expertise and accountability to better manage financial resources across service sectors (California Center for Research on Women & Families [CCRWF], 2001; Flynn & Hayes, 2003; Koyanagi, 2003a). The benefits of such an approach, as documented in evaluations of ongoing programs that use pooled funding streams, include—

- Identifying and filling gaps in services;
- Eliminating duplicative services;
- Increasing flexibility in the use of existing and expanded services; and

3. Considerations Regarding Whether to Blend or Braid Funding Streams

The research approach taken in describing and evaluating pooled funding streams was predominantly based on qualitative methods such as interviews with key stakeholder experts in sites that have implemented this financing approach, site visits, and document analyses. Authors then compared and contrasted findings across sites to identify common themes, challenges, and successes. These reports described the pros and cons of pooling funding streams in general, and then, once pooled, distinguished between blending or braiding of funds and the respective programmatic and financial issues that sites have identified and techniques deployed to address them.

Analyses that have evaluated pooled funding systems report that the choice of whether
to blend or braid funding streams involves several considerations, including—

- How State agencies are organized and financed;
- Stakeholders’ willingness to collaborate; and
- The costs of creating an expert management information system that can accurately track all expenditures and ensure that all legal requirements contained in funding authorities are met.

Blending funding streams may require overcoming reluctance on the part of agency heads who, through pooling of funds, may feel that they are losing control over how their funds, for which they are accountable, will be spent. Thus, the amounts they may be willing to offer may be lower than what could be achieved through a braided funding approach that retains more individual agency control. Braiding funding streams requires developing and financing a complex and potentially expensive fiscal monitoring system to ensure a single point of accountability for assessing appropriate delivery of services and allocations of costs across funding streams (Crowell, DelliQuadri, & Austin, 1995; Hodges, Nesman, & Hernandez, 1998; Koyanagi, 2003a; Koyanagi & Feres-Merchant, 2000; O’Brien, 1997; Orland & Foley, 1996; Pires, 2002; Potter & Mulkern, 2004).

4. **Blending or Braiding Funding Streams: Key Elements for Success**

In both blended and braided funding approaches, there are several key elements that support their successful creation and implementation. Figure 8 summarizes these common themes and recommendations as identified in numerous studies and evaluations in the literature.

**Summary of the Literature:** The nature of the literature regarding the use of pooled funding streams is primarily qualitative evaluations based on interviews with key stakeholder experts, by conducting site visits, administering surveys, and document content analyses. Blending or braiding multiple funding streams across service sectors is a desirable way to (1) overcome fragmented multiple mental health treatment systems; and (2) enhance flexibility to provide access to a coordinated array of mental health, medical, and social services that result in better outcomes for children and families with mental health needs. Both approaches require a high level of collaboration and coordination among stakeholders. Merging funds in these ways also requires the development of sophisticated financial and health outcomes monitoring systems to document adherence to fiscal and legal integrity requirements, as well as to document improvements in health status and system viability.

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*Special Report*
ESTABLISHING THE BEHAVIORAL HEALTH INTERAGENCY COOPERATIVE

Whereas, Idaho citizens and their families should have appropriate access to quality services provided through the public mental health and substance use disorders systems that are coordinated, efficient and accountable; and

Whereas, the Behavioral Health Transformation Work Group established by Executive Order 2010-01 was tasked to develop a plan for a coordinated, efficient state behavioral health infrastructure with clear responsibilities, leadership authority and action;

Whereas, the Behavioral Health Transformation Work Group has worked diligently to develop an integrated structure and coordinated delivery system;

Whereas, the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) codified in section 39-303 Idaho State Code, is set to sunset on June 30, 2011;

Whereas, ICSA has made progress in bringing about open communication between stakeholders and providers resulting in meaningful reform of the state’s substance use disorders system and this effort should continue; and

Now, therefore I, C.L. “Butch” Otter, Governor of the State of Idaho, by the authority vested in me under the Constitution and laws of this state do hereby create the Behavioral Health Interagency Cooperative (Cooperative).

1. Members of the Cooperative shall be appointed or approved by (as appropriate) and serve at the pleasure of the Governor.

2. The Chair of the Cooperative shall be appointed by and serve at the pleasure of the Governor.

3. The members of the Cooperative shall include but are not limited to:
   a. Director, Department of Health and Welfare;
   b. Director, Department of Correction;
   c. Director, Department of Juvenile Corrections;
   d. Superintendent of Public Instruction;
   e. Administrative Director of Idaho Courts;
f. One representative from among the Counties;

g. One representative from the State Planning Council.

4. The Cooperative shall:

a. Work in coordination with the Director of Transformation, once appointed, to secure a coordinated and effective system (who will chair the Cooperative once appointed);

b. Work in close coordination with local and state government, the judiciary, and specifically with the Office of the Governor and members of the Senate and House Committees on Health and Welfare;

c. Provide input to draft legislation regarding transformation of the behavioral health system as it is under development and worked through the legislative process;

d. Review and confirm recommendations, statewide standards, guidelines, contract templates, core services, and other elements of the behavioral health system as they are developed by respective entities;

e. Ensure the implementation of the transformation of as described in the BHTWG Plan for Transformation of Idaho's Behavioral Health System (October 2010), by providing for efficient and effective interagency coordination of systems, operations, services, and a braided funding process;

f. Produce and present a status report of their interagency efforts and accomplishments to the Office of the Governor and members of the Senate and House Committees on Health and Welfare on an annual basis;

g. Meet on a monthly basis, or more frequently as needed to meet the needs of the group;

h. Develop, annually update, and commit to implementing the Statewide Behavioral Health Cooperative Transformation Implementation Plan that is equally applicable to all entities involved with the Cooperative. The Transformation Implementation Plan will address:

- Overall policies, strategies, steps, and timelines related to transformation implementation;
- Strategies for coordination, cooperation, collaboration, forging partnerships and understandings between behavioral health, education and justice systems;
- Agreement on the agency staff responsible for specific duties related to the transformation and operation of the behavioral health system as well as a system to ensure accountability to the plan;
- Statewide behavioral health needs and gaps;
- A braided funding strategy which coordinates budgets, establishes priorities and addresses issues of funding availability;
- Data and information sharing, reports and functionality;
- Coordinated approaches for the delivery of behavioral health services and the elimination of duplication of services among relevant agencies;
▪ Readiness criteria for regional contracting;
▪ Workforce development and training for public and private providers, including multidisciplinary approaches;
▪ Best practices;
▪ Ongoing communication strategies;
▪ System performance and evaluation and outcome-based performance measures; and
▪ The role of behavioral health in Health Care Reform.

g. The Cooperative will:

▪ Identify and forward prospective candidates for the position of Director of Transformation;
▪ Collect and share data needs and requirements and propose how data can be effectively coordinated/cross-walked across agencies;
▪ Quantify total state funding across entities so that regions and the state can plan for the most effective use of taxpayer dollars;
▪ Share funding information on a regional scale with regional boards so that they can provide informed input about their needs and priorities;
▪ Participate in a braided funding scenario where funding streams from various sources are coordinated to support a broad continuum of behavioral health services;
▪ Articulate their respective needs and requirements for use in Regional Provider Network contracting and evaluation processes;
▪ Confirm a shared understanding of service standards developed by DHW, which operates as the State Behavioral Health Authority and who will monitor for performance based on consistent service standards statewide; and
▪ Purchase services through the Regional Provider Networks through contractual arrangement(s) which articulate shared service standards, collects and shares system-wide data, meets reporting requirements of state and federal funding entities, provides for the best use of the taxpayer dollar, and secures the best outcomes for the family and consumer.

5. An Office of Performance Evaluation review will be delivered on January 1, 2016. Authority for the Cooperative shall sunset on June 30, 2016, pending the result of the January 1, 2016 report.

In Witness Whereof, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho in Boise on this _____ day of ______ in the year of our Lord two thousand and ______ and of the Independence of the United States of America the two hundred _________ and of the Statehood of Idaho the one hundred __________.
Attachment E: Definitions of Core Services

Assertive Community Treatment (ACT), Intensive Case Management Services and Wraparound

**Assertive Community Treatment (ACT)**
ACT consists of proactive interventions with serious, disabling mental illness for the purpose of increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology, and ensuring a satisfactory quality of life. Services include the provision and coordination of treatments and services delivered by multidisciplinary teams using an active, assertive outreach approach and including comprehensive assessment and the development of a community support plan, ongoing monitoring and support, medication management, skill development, crisis resolution, and accessing needed community resources and supports.

**Intensive Case Management**
Intensive case management is an intensive community rehabilitation service for individuals at-risk of hospitalization or for crisis residential or high acuity substance use disorders services. Services include: crisis assessment and intervention; individual restorative interventions for the development of interpersonal, community coping and independent living skills; development of symptom monitoring and management skills; medication prescription, administration and monitoring; and treatment for substance use disorders or other co-occurring disorders. Intensive case management also includes coordinating services, referral, follow-up, and advocacy to link the individual to the service system. Services can be provided to individuals in their home, work or other community settings. Services may be provided by a team or by an individual case manager.

**Wraparound**
Wraparound is an intensive and individualized care management process. During the wraparound process, a team of individuals who are relevant to the well-being of the individual (e.g., family members, other natural supports, service providers, and agency representatives) collaboratively develop an individualized plan of care, implement this plan, and evaluate success over time. The wraparound plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family’s social networks. The team convenes frequently to measure the plan’s components against relevant indictors of success. Plan components and strategies are revised when outcomes are not being achieved.

**Assessment and Evaluation**
Assessment and evaluation define or delineate the individual’s mental health/substance use disorders diagnosis and related service needs. Assessments and evaluations are expected to be timely and of high quality and provided by trained and experienced professionals. Assessment and evaluation services are used to document the nature of the individual’s behavioral health status in terms of interpersonal, situational, social, familial, economic, psychological, substance use disorder and other related factors. These services include at least two major components: 1) screening and evaluation (including medical, bio-psychosocial history; home, family, and work environment assessment; and physical and laboratory studies/testing and psychological testing as appropriate); and 2) a written report on the evaluation results to impart the evaluator’s professional judgment as to the nature, degree of severity, social-psychological functioning, and recommendations for treatment alternatives.
**Case Management (service coordination)** (case load capacity to be determined by an acuity-based formula)

This service provides supportive interventions to assist individuals to gain access to necessary medical, habilitative, rehabilitative and support services to reduce psychiatric symptoms, address substance use disorders, and develop optimal community living skills. Service Coordination needs are assessed and documented on the comprehensive treatment plan to meet the individual’s specific needs. Service Coordination services may include coordinating services, referral, follow-up, and advocacy to link the individual to the service system and to coordinate the various system components to assure that the multiple service needs of the individual are met. Service Coordination may also provide assistance for obtaining needed services and resources from multiple agencies (e.g., Social Security, Medicaid, Prescription Assistance Programs, food stamps, housing assistance, health and mental health care, child welfare, special education, etc.), advocating for services, and monitoring care. Case management also assists in the transition of adolescent consumers as they age out of the children's system and into the adult system and the transition to adulthood.

**Designated Examinations and Dispositions**

A designated examination is a personal examination of a proposed patient to determine if the proposed patient is: (i) mentally ill; (ii) likely to injure himself or others or is gravely disabled due to mental illness; and (iii) lacks capacity to make informed decisions about treatment and should be involuntarily committed to the Department of Health and Welfare (Department). A designated examiner must be a psychiatrist, psychologist, psychiatric nurse, social worker or other mental health professional designated in rule and specially qualified by training and experience in the diagnosis and treatment of mental illness. A dispositioner is a designated examiner employed by or under contract with the Department to determine the least restrictive appropriate location for care and treatment of involuntary patients.

**Intensive Outpatient Treatment**

**Home-Based Mental Health Services**
Intensive home-based treatments are time-limited intensive therapeutic and supportive interventions delivered in the home. They are intended to prevent hospitalization. These services are available twenty-four hours a day, seven days a week. Services are multi-faceted in nature and include: situation management, environmental assessment interventions to improve individual and family interactions, skills training, self and family management, and independent living skills training.

**Intensive Outpatient Substance Use Disorder Treatment**
This service provides a time limited, multi-faceted approach treatment for persons who require structure and support to achieve and sustain recovery. Intensive outpatient treatment consists of group and family counseling, job preparedness, relapse prevention, and education.

**Illness Self-Management and Recovery Services**

Illness self-management uses structured techniques and strategies for managing mental illness/substance use disorders and ongoing self-assessment and self-monitoring to facilitate recovery from mental illnesses/substance use disorders. Several manualized self-management programs have been developed in recent years, including programs designed to help participants identify internal and
external resources for facilitating recovery, and then use these tools to create their own, individualized plan for successful living.

**Inpatient Psychiatric Hospitalization**

The goal of inpatient care is to stabilize the individual displaying the acute symptoms. This service is available for individuals who are in direct danger to self or others, and/or in acute crisis, including substance use withdrawal. This service provides twenty-four (24) hour care in a hospital requiring short-term, intensive, medically supervised treatment, consistent with the individual’s needs. Services provided in an acute psychiatric hospital include, but are not limited to, psychiatric care, monitoring of medication, health assessment, nutrition, therapeutic interventions, observation, case management and professional consultation.

**Medication Management**

**Medication Management/Pharmacotherapy**

Medication management is a pharmacotherapy service provided by a psychiatrist, physician or other individual licensed to prescribe medications to assess and evaluate the individual’s presenting conditions and symptoms, medical status, medication needs and/or substance use disorders status. This includes evaluating the necessity of pharmacotherapy or other alternative treatments, prescribing, preparing, dispensing, and administering oral or injectable medication. Informed consent must be obtained for each medication prescribed.

**Medication Administration/Monitoring**

Medication services are goal-directed interventions to administer and monitor pharmacological treatment. Oral, injectable, intravenous, or topical medications and treatments are administered and their positive and negative effects monitored. This includes medications used to treat substance use disorders or addiction. There is a focus on educating and teaching individuals and members of their support system as to the effects of medication and its impact on alcohol/drug abuse/dependence and/or mental illness. Counseling related to medication management and case coordination with other practitioners involved with the individual is necessary to assure continuity of care. These are primarily face-to-face services contacts, rendered as both facility-based and “in vivo.”

**Drug Screenings**

Laboratory screenings are used to treat behavioral health and medical disorders and provide pharmacologic management. Tests may include, but are not limited to: urinalysis, other formal drug screenings and blood tests.

**Peer Support Services**

Peer support services provide an opportunity for individuals to direct their own recovery and advocacy process and to teach and support each other in the acquisition and exercise of skills needed for management of symptoms and for utilization of natural resources within the community. This service provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of other natural supports, and maintenance of community living skills. Trained and certified consumers actively participate in decision-making and the operation of the programmatic supports.
Prevention Services

The goal of this service is to prevent suicide, mental illness, and/or substance use disorders. Prevention activities include various strategies aimed at educating the community at large and selective educational and informational strategies for certain individuals who are at greatest risk for suicide, mental illness and/or substance use disorders. A system of prevention involves clear boundaries and expectations, and a comprehensive scope of pro-social activities and educational services designed to increase protective factors and reduce risk factors among all in a community (universal). One of the keys to prevention of suicide, mental illness and substance use disorders is training "gatekeepers" in how to recognize the early signs and symptoms. Gatekeepers are those individuals that have frequent contact with moderate to high risk populations.

Early Intervention Services for Children and Adolescents

Early intervention services are designed to address problems or risk factors that are related to mental illness and substance use disorders. These services are designed to provide information, referral and education regarding symptoms and treatment to assist the individual in recognizing the risk factors for mental illness and substance use disorders. Early intervention and education is an organized service that may be delivered in a wide variety of settings. Early intervention may include time-limited respite care services.

Psychiatric Emergency and Crisis Intervention Services (24/7 with open door access)

Crisis Intervention/Mobile Crisis
Crisis intervention services are immediate, crisis-oriented services designed to ameliorate or minimize an acute crisis episode and to prevent inpatient psychiatric hospitalization or medical detoxification. Services are provided to adults, adolescents and their families or support systems who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors or moods. The services are characterized by the need for highly coordinated services across a range of service systems. Crisis intervention services should be available on a 24-hour, seven-day per week basis. Services can be provided by a mobile team or by a crisis program in a facility or clinic. Crisis intervention services include: crisis prevention, acute crisis services, and support services.

Crisis Residential Treatment/Respite Care Services
Crisis residential treatment services provide 24 hour supports for adults for the purpose of ameliorating a crisis in the least restrictive setting while trying to maintain the person’s linkages with their community support system. Services include: continuous and close supervision, medical, nursing and psychiatric services and referral to community-based services. Crisis residential treatment services are provided in non-hospital setting. Crisis residential lengths of stay generally should not exceed 10 days.

Psychotherapy (including trauma-informed care, cognitive behavioral therapy and outpatient substance use disorders treatment.)

Individual
Individual counseling consists of various evidence-based professional therapeutic interventions and is used to address an individual’s alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, connecting with and utilizing
natural supports, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various settings.

**Group**

Group psychotherapy consists of therapeutic interventions provided to a group of children, adolescents or adults to address an individual’s alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various settings. Group size should be at least three or more, but fewer than 10 individuals.

**Family Psychotherapy for Children and Adolescents**

Interventions directed toward an individual and family to address emotional or cognitive problems which may be causative/exacerbating of the primary mental disorder or have been triggered by the stress related to coping with mental and physical illness, alcohol and drug abuse, and psychosocial dysfunction. Personal trauma, family conflicts, family dysfunction, self-concept responses to medication, and other life adjustments reflect a few of the issues that may be addressed. Includes Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Parenting with Love and Limits (PLL).

**Alcohol and Drug Residential Treatment**

This service is a twenty-four hour residential rehabilitation treatment for adults or adolescents with chronic alcoholism or drug dependency who lack an adequate social support system and need supervised treatment to achieve a substance-free lifestyle and explore and instill ways of functioning in a work setting, within the family, and in the community in accordance with the individual’s treatment plan. Services include: medication administration, case management and monitoring and individual and group recovery-based services. Some individuals may be experiencing and be monitored for minor detoxification.

**Supported Employment, including Vocational Rehabilitation when needed**

**Supported Employment**

Supported employment provides on the job supports in an integrated work setting with ongoing support services for adults with the most severe disabilities for whom competitive employment: a) has not traditionally occurred; b) has been interrupted or intermittent as a result of severe disability; and c) who, because of the nature and severity of their disability, need intensive supported employment services in order to perform work. Activities are performed by a job coach and/or job specialist/case manager in conjunction with a job developer to achieve a successful employment outcome.

**Job Preparedness**

Job preparedness consists of activities directed at assisting individuals to develop skills to gain and maintain employment. Job preparedness services include: providing instruction in the areas of resume writing, job application preparation, and appropriate job interview responses. These activities also emphasize the importance of being ready to seek and hold employment is discussed, including proper nutrition, cleanliness, and physical appearance, allocating daily costs, and taking prescribed medication.
Supported Housing (housing first, etc.)

Supported housing is a safe and secure place to reside which is affordable to consumers and permanent as long as the consumer pays the rent and honors the conditions of the lease. In some models, consumers are not required to participate in services to keep their housing, although they are encouraged to use services. Supported housing should be individualized services available when the consumer needs them and where the consumer lives.

Transformation

Transformation services are used to move individuals to and from covered medically necessary medical or behavioral health examinations, treatment and services. This service may be provided in staff-driven vehicles, or by assistance with the cost or process of arranging for and/or using public or private transformation.

24-hour Out-of-Home Treatment Interventions for Children and Adolescents

Residential Treatment
Time limited services are designed to assist children or adolescents to develop skills necessary for successful reintegration into the family or transition into the community. Residential treatment centers provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to eligible recipients. Services provided in this setting include: individual, groups and family therapy, behavior management, skill building and recreational activities. Services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment.

Treatment Foster Care
Time limited community based treatment services provided to children or adolescents who are placed in 24-hour supervised, trained and surrogate family settings. Intensive therapeutic foster care services incorporate clinical treatment services, which are behavioral, psychological and psychosocial in orientation. Services must include clinical interventions by the specialized therapeutic foster parent(s) and a clinical staff person. Services included in individualized care plans are designed to assist the child or adolescent to develop skills necessary for successful reintegration into the natural family or transition into the community. The family living experience is the core treatment service.

Day Treatment/Partial Care Services and Partial Hospitalization

a. Day Treatment and Partial Care for Children and Adolescents
A non-residential treatment program designed for children and adolescents who may be at high risk of out-of-home placement. Therapeutic Day Treatment services are a coordinated and intensive set of therapeutic, individual, family, multi-family and group services and social recreational services. Day Treatment Services provide a minimum of three hours of structured programming per day, two-to-five times a week, based on acuity.

b. Partial Hospitalization for Adults
A distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care that is reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization.
State of Idaho
Epidemiological Profile
Of Substance Abuse 2011

State Epidemiological Outcomes
Workgroup Report

Prepared by:
Idaho Department of Health and Welfare
Division of Behavioral Health
Bureau of Quality Assurance and Policy
Data Unit
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Executive Summary

Idaho has a relatively small population compared to its western neighbors. Only Wyoming and Montana have smaller state populations. Both alcohol induced deaths and drug induced deaths are higher in the west than the rest of the nation. Compared to other states in the west, substance abuse indicators are generally moderately low in Idaho.

Survey data indicates that within the state, Regions 3, 1, and 2 have the highest percentages of past month alcohol use and binge drinking. DUI arrest rates support this evidence. The survey data also indicates that the percent of illicit drug use is highest in Region 2, but rates of drug related arrests are the lowest in this region. Marijuana arrest rates are highest in Region 1, methamphetamine arrest rates are highest in Regions 5 & 4, and cocaine arrest rates are highest in Region 2. This information hints that each region might have its own different “preferred substance.”

In 2006, 35% of treatment admissions in Idaho were for amphetamine treatment, 23% of admissions were for marijuana, 23% of admissions were for alcohol as a primary drug. Adult treatment admissions for alcohol, marijuana, and methamphetamine have increased between 52% -73% since 2005. Youth treatment admissions have dropped for meth, increased 15% for alcohol, and jumped 36% for marijuana since 2005.

Adult smoking is at a ten year low, however, after a steady decrease in youth smoking for the last ten years, smoking among 10th and 12th graders increased slightly from 2004 to 2006.
Introduction
This profile is an attempt to gain better understanding of substance use and abuse patterns within a specific geographic area. The profile relies mainly on three potential sources of data for information on substance users; surveys containing self-reported data on substance abuse, drug-related arrest data, and mortality data. While these information sources are good, they do have limitations. As such, this profile should be combined with other data sources (e.g., local experts, other archival data) to provide a more thorough basis for understanding substance use practices within the specific areas of the state.

In an effort to provide a more useable product to our stakeholders, the Idaho State Epidemiological Outcomes Workgroup selected to update and change the format previously implemented in past years for the State of Idaho Epidemiological Profile. For methodological and purpose driven reasons, some previously reported data that is still available was not reported in this year’s profile. For any questions beyond the contents of this report, feel free to contact the appropriate individual or program listed as a partner in Appendix A.

Demographics
To better understand the state of Idaho this portion of the profile examines the various parts of the state by Division of Behavioral Health Region and county. The seven health regions contain multi-county areas. Small county populations contribute to low occurrences of substance abuse. These larger areas can assist in identifying broader substance abuse patterns and trends.

Figure 1

The following eight maps highlight demographic characteristics of Idaho. Regional boundaries in some cases have been overlaid in red for clarification. See Appendix B for map with labels referencing Idaho counties.
Idaho Population, 2008

Idaho’s most populated counties are Ada, Canyon, and Kootenai counties. Idaho’s population in 2006 was 1,499,402, up 15.9% from the 2000 Census. During the 1990’s the population in Idaho increased by 28.5 percent and this rate of growth still occurs in some areas. The population growth in metropolitan areas has continuously outpaced growth in nonmetropolitan areas.

Idaho Population Change, 2000-2008

Those counties with the greatest loss of population include Clark (-11.4%), and Clearwater (-7.8%). Counties with greatest population increases include Canyon (36.5%), Teton (39.2%), and Ada (24.1%).
**Figure 4**

The percent of the population age 25 and over that has earned either a Bachelor’s Degree or higher is 24.4% nationally. In Idaho that rate is 21.7%.

---

**Figure 5**

In 2004, nationally, the percent of the population in poverty was 12.7%, and in Idaho the rate was 11.5%. The counties with the lowest percent of the population in poverty were Blaine (5.9%) and Camas (7.3%). Counties with the highest percent of the population in poverty included Shoshone (16.3%), Madison (15.6%), and Owyhee (15.4%).
In 2005, the national rate of per capita income was $34,471. Within Idaho the average per capita income was $28,478. Per capita income in the counties ranged from $16,489 in Madison County to $52,245 in Blaine County.

*Figure 6*

Idaho retains its agricultural and rural roots. The majority of Idaho’s counties are specialized in farming, mining, manufacturing, government, or services. When compared by shear area, 28% of Idaho (23,736 Sq miles) is dedicated to farming and 33% (27,901 Sq miles) is dedicated to government use such as BLM, US Forest Service, and US Air Force. Only 13 of the counties in Idaho have a broad enough economic base to be considered non-specialized.

*Figure 7*
Unemployment Rate, March 2008

**Figure 8**

The 2008 unemployment rate in Idaho was 4.1%, compared to 5.1% for the nation. In the counties, the unemployment rate ranged from 2.3% in Owyhee and Teton Counties, to 12.9% in Clearwater County.

As you can see from Figure 9, Idaho is greatly underserved medically in its rural areas. A vast majority of the primary care physicians in the state are located in one of the states metropolitan areas.

**Figure 9**
Methodology

The State of Idaho Epidemiological Profile of Substance Abuse has been developed under the State Epidemiological Outcomes Workgroup (SEOW) Contract and in turn the methodology used to develop this report is a standard format provided to all SEOWs. The following is a review of that methodology developed by the Pacific Institute for Research and Evaluation.

Substance abuse prevention planning begins with a clear understanding of alcohol, tobacco, and other drug use and their chief consequences (Figure 10).

In such an outcome-based approach, understanding the nature and extent of substance use and related problems (consumption and consequences) is critical for determining prevention priorities and aligning relevant and effective strategies to address them. CSAP recommended that State epidemiological profiles predominantly focus on substance use and related consequences as the first step in developing an outcomes based approach to prevention.1

CONSUMPTION:

Consumption is defined as the use and high-risk use of alcohol, tobacco, and illicit drugs. Consumption includes patterns of use of alcohol, tobacco, and illicit drugs, including initiation of use, regular or typical use, and high-risk use.

CONSEQUENCES:

Substance-related consequences are defined as adverse social, health, and safety consequences associated with alcohol, tobacco, or illicit drug use. Consequences include mortality and morbidity and other undesired events for which alcohol, tobacco, and/or illicit drugs are clearly and consistently involved. Although a specific substance may not be the single cause of the consequence, scientific evidence must support a link to alcohol, tobacco, or illicit drugs as a contributing factor to the consequence.

Each of the two major groupings (consumption and consequences), can be broken down into discrete categories or prevention-related “constructs” for each of the three major substance types—alcohol, tobacco, and illicit drugs. The constructs provide a way to conceptualize and organize key types of consumption patterns and consequences. For example, with respect to alcohol, constructs related to consequences include mortality and crime and constructs related to consumption patterns include current binge drinking and age of initial use. For each construct Idaho attempted to fine one or more

1 Focusing on consumption and consequences does not by any means undermine the importance of measuring and understanding causal factors that lead to substance abuse and substance abuse-related consequences. Understanding the factors that contribute to substance use and related problems (also referred to as “intervening variables or “risk and protective factors”) is the logical next step after the State has developed a full understanding of the substance use patterns and consequences it seeks to address.
specific data measure (or “indicators”) to assess and quantify the prevention-related constructs. Idaho’s indicator data is collected and maintained by the various community and government organizations that are listed in Appendix A.

Numerous constructs and indicators for substance use and related consequences exist at the national, State, and sub-State level. Assembling and interpreting all of the available prevention-relevant data, however, would be an overwhelming challenge. Starting with a set of key constructs assisted Idaho in organizing and narrowing our search for data relevant to the particular decisions Idaho needed to make. As suggested by PIRE, Idaho was guided in this process by what we wanted to know rather than starting with an inventory of all the data we have. That is, Idaho didn’t let the existence of data drive decisions about which problems to focus on. We first specified the constructs of real interest and then identified what indicators were available to measure those constructs. If no data was available we choose not to represent that construct.

Given the limited time and resources for data analysis and interpretation, the Idaho SEOW focused on those constructs and indicators that proved most useful for prevention decision-making. All indicators included in this profile have been found to be valid and reliable measures of the constructs they were intended to reflect. Additionally, with respect to consequences, this meant focusing on constructs for which there is strong research evidence regarding the causal influence of alcohol, tobacco, and/or illicit drug use.
Data sources & Indicators
An effort was made to ensure that as many constructs as possible were represented by the fact sheets in the profile. For the data associated with each indicator refer to the fact sheet for the corresponding source.

### Alcohol Related Indicators

#### Alcohol Consumption

<table>
<thead>
<tr>
<th>Construct</th>
<th>Indicator</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Use</td>
<td>Percent of persons aged 18 and over reporting any use of alcohol in the past 30 days</td>
<td>DHW-BRFSS</td>
</tr>
<tr>
<td></td>
<td>Percent of students in grades 9 through 12 reporting any use of alcohol in the past 30 days</td>
<td>Education</td>
</tr>
<tr>
<td>Heavy drinking</td>
<td>Percent of adults aged 18 and older reporting average daily alcohol consumption greater than 2 (male) drinks or greater than 1 drink (female) per day</td>
<td>DHW-BRFSS</td>
</tr>
<tr>
<td>Age of initial use</td>
<td>Percent of students in grades 9 through 12 who report first use of alcohol before age 13</td>
<td>Education</td>
</tr>
</tbody>
</table>

#### Alcohol Consequences

<table>
<thead>
<tr>
<th>Alcohol-related mortality</th>
<th>Number of deaths attributable to alcohol per 100,000 population</th>
<th>DHW-VS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crime</td>
<td>Number of DUI arrests per 1000 population</td>
<td>ISP</td>
</tr>
<tr>
<td></td>
<td>Number of alcohol related arrests per 1000 population</td>
<td>ISP</td>
</tr>
<tr>
<td></td>
<td>Number of DUI court filings per 1000 population</td>
<td>Courts</td>
</tr>
</tbody>
</table>
### Tobacco Related indicators

#### Tobacco Consumption

<table>
<thead>
<tr>
<th>Construct</th>
<th>Indicator</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Use</strong></td>
<td>Percent of persons aged 18 and older who report smoking 100 or more cigarettes in their lifetime and now smoke cigarettes either every day or on some days</td>
<td>DHW-BRFSS</td>
</tr>
<tr>
<td></td>
<td>Percent of students in grades 9 through 12 reporting any use of cigarettes in the past 30 days</td>
<td>Education</td>
</tr>
<tr>
<td></td>
<td>Percent of students in grades 9 through 12 reporting any use of smokeless tobacco in the past 30 days</td>
<td>Education</td>
</tr>
<tr>
<td><strong>Daily use</strong></td>
<td>Percent of adults aged 18 and older who report smoking 100 cigarettes in their lifetime and now smoke every day</td>
<td>DHW-BRFSS</td>
</tr>
<tr>
<td><strong>Age of initial use</strong></td>
<td>Percent of students in grades 9 through 12 initiating tobacco use before age 13</td>
<td>Education</td>
</tr>
</tbody>
</table>

#### Tobacco Consequences

<table>
<thead>
<tr>
<th>Tobacco-related mortality</th>
<th>Number of deaths from lung cancer per 100,000 population</th>
<th>DHW-VS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of deaths from cardiovascular disease per 100,000 population</td>
<td>DHW-VS</td>
</tr>
</tbody>
</table>
## Drug Related Indicators

### Illicit Drug Consumption

<table>
<thead>
<tr>
<th>Construct</th>
<th>Indicator</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Use</strong></td>
<td>Percent of students in grades 9 through 12 reporting any use of marijuana in the past 30 days</td>
<td>Education</td>
</tr>
<tr>
<td></td>
<td>Percent illicit drug use in the past 12 months</td>
<td>DHW-BRFSS</td>
</tr>
<tr>
<td><strong>Lifetime use</strong></td>
<td>Percent of students in grades 9 through 12 reporting any use of methamphetamines in their lifetime</td>
<td>Education</td>
</tr>
</tbody>
</table>

### Illicit Drug Consequences

<table>
<thead>
<tr>
<th>Drug-related mortality</th>
<th>Number of deaths from illicit drug use per 100,000 population</th>
<th>DHW-VS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crime</strong></td>
<td>Number of drug/narcotic possession and distribution arrests per 1000 population</td>
<td>ISP</td>
</tr>
<tr>
<td></td>
<td>Number of drug related filings per 1000 population</td>
<td>Courts</td>
</tr>
</tbody>
</table>

## Fact Sheets

The following pages contain fact sheets from the Idaho SEOWs various partners. This format has been developed in the interest of providing a clear line of communication between our stakeholder’s and the data managers and analysts. With that in mind, stakeholders should feel free to distribute these fact sheets individually or as a package.
Heavy drinking, Cigarette smoking, Illicit drug use

“Heavy drinking” is defined as the percent of adults aged 18 and older reporting average daily alcohol consumption greater than 2 (male) drinks or greater than 1 drink (female) per day.

“Cigarette smoking” is defined as the percent of persons aged 18 and older who report smoking 100 or more cigarettes in their lifetime and now smoke cigarettes either every day or on some days.

“Illicit drug use” is defined as the percent of individuals who used illicit drugs in the past 12 months.
“Current drinkers” is defined as the percentage of Idaho students who had at least one drink of alcohol during the past 30 days. This has not changed significantly from 2001 to 2009.

“Alcohol age of initiation” is defined as the percentage of Idaho students who had their first drink of alcohol other than a few sips before age 13 years. The age of initiation for alcohol (first drink before age 13) has dropped significantly from 27.6% in 2001 to 19.2% in 2009.

“Current smokers” is defined as the percentage of Idaho students reporting any use of cigarettes in the past 30 days. After increasing significantly from 14.0% in 2003 to 20% in 2007, the current smoking rate among Idaho high school students dropped again to a near low of 14.5% in 2009.

“Current smokeless tobacco users” is defined as the percentage of Idaho students reporting any use of smokeless tobacco in the past 30 days. Past month chewing tobacco use increased significantly from 5.7% in 2003 to 11.8% in 2007.

“Tobacco age of initiation” is defined as the percentage of Idaho students initiating tobacco use before age 13. The percentage of Idaho students who smoked a whole cigarette for the first time before the age of 13 decreased significantly from 19.2% in 2001 to 8.7% in 2009.
"Current marijuana user" is defined as the percentage of Idaho students reporting any use of marijuana in the past 30 days. The percentage of Idaho students who used marijuana one or more times during the past 30 days has not changed significantly since 2001.

"Lifetime methamphetamines" is defined as the percentage of Idaho students who used methamphetamines one or more times during their life. Lifetime meth use peaked in 2001 at 7.2% and decreased to a low of 3.1% in 2009.
Reporting of Abuse, Abandonment, or Neglect – Idaho Code 16-1605 Section 1: "Any... person having reason to believe that a child under the age of eighteen (18) years has been abused, abandoned or neglected or who observes the child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment or neglect shall report or cause to be reported within twenty-four (24) hours such conditions or circumstances to the proper law enforcement agency or the department". To report child abuse or neglect call the Idaho Careline 2-1-1 or 1-800-926-2588. Referrals shown above do no include: Third Party, Court Ordered Investigation, Information & Referral, or CP Expansion.

Referrals dispositioned as substantiated are child abuse and neglect reports that are confirmed by one or more of the following: witnessed by a child welfare worker, determined or evaluated by a court at the adjudicatory hearing, a confession, corroborated by physical or medical evidence, or established by evidence that is more likely than not that abuse, neglect, or abandonment occurred. Substantiations shown above do no include: Court Ordered Investigation or CP Expansion.

Source: Kids Count Report in Family Oriented Community User System (FOCUS) and U.S. Census Bureau population estimates
Idaho State Police (ISP)

Alcohol

Idaho DUI and Other Alcohol Related Arrest Rates per 1,000 Population: 2005 - 2009

DUI arrests include misdemeanor and felony DUI arrests. While “Other Alcohol Related Arrests” include liquor law violations, public drunkenness, and minor in possession charges.

Drugs

Idaho Drug/Narcotic Possession and Distribution Arrest Rate per 1,000 Population: 2005 - 2009
Idaho Supreme Court
State DUI and Drug Court Filings

The information above represents the rate of Felony Court Filings in the District Court per 1000 people for the state of Idaho per calendar year.

The information above represents the rate of Misdemeanor Court Filings in the Magistrate Court per 1000 people for the state of Idaho per calendar year.
DHW – Vital Statistics (VS)
Alcohol and Tobacco Related Mortality

All mortality figures are deaths per 100,000 residents.

Major Cardiovascular Deaths

Drug Induced Mortality
Data Limitations & Gaps

On a methodological level, Idaho struggles to collect indicators that directly describe and measure substance abuse rather than aspects related to usage. Among other issues, survey/self-report data has often been exposed as unreliable in a state with a demographic as diverse as Idaho’s. Statistical modeling assumes a certain degree of homogeneity that simply is not present. This, coupled with the low funding levels, results in small sample sizes with questionable validity. As a result we’ve attempted to use capacity measures as a substitute for reliable survey data, but in the future efforts may be undertaken to expand the sample sizes on both the NSDUH and BRFSS to remedy this issue.

In some cases this issue can be remedies by aggregating data by region, but that creates additional complication. While it is certainly easier to discuss seven regions than it is to discuss 44 counties, a great deal of detail is lost in the conversion to regions. Since only some of our counties are demographically similar to those counties that adjoin them, mean regional scores can mischaracterize trends occurring in the rural and frontier counties that represent the majority of the states land mass.

These issues lead to capacity measures composing a majority of the indicators in this report. But of those capacity measures, the state has a serious gap in coverage. Idaho lacks a hospital discharge database. In many states this is the major source of the morbidity indicators which Idaho lacks in totality. Finally, database cardinality is a persistent issue in many of the systems which report the epidemiological indicators. Particularly in regards to education which lacks even a client level database.

Conclusions

While consumption and many consequences seem to be on the fall there are a couple of notable consequences on the rise. Felony DUI filings have raised sharply over the course of the past 5 years. Additionally drug induced mortality is on the rise.

In the case of felony DUls, in recent years there was a revision to Idaho statute 18-8005 which guides DUI penalties. A large number of DUls previously defined as misdemeanor are now being classified as felony as a result of an expanded time window (from five years to ten years) for multiple DUls. That said, while felony DUls have been on the rise, misdemeanors have been on the fall. This may indicate a stable DUI rate.

Drug induced mortality is significantly more complicated. While other mortality rate indicators have been on the fall or stagnant, drug induced mortality has risen 28% in the past two years. This is a disturbing tread which will be monitored. While the national rate for those two years has not been released at this date—this, coupled with a detailed analysis of drug typology may yield an explanation.

By in large, the preponderance of falling indicators may indicate that community based prevention efforts began in 2006 are beginning to have an effect. Further research to reject possible intervening variables (such as a depressed economy) must be conducted but the initial results contained in this report are encouraging.
**Appendices**

**Appendix A – Sources contact information**

<table>
<thead>
<tr>
<th>Sources</th>
<th>Agency</th>
<th>Individual</th>
<th>Contact Info (email or phone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHW-BRFSS</td>
<td>Idaho DHW – Vital Statistics</td>
<td>Christopher Murphy</td>
<td><a href="mailto:murphyc@dhw.idaho.gov">murphyc@dhw.idaho.gov</a></td>
</tr>
<tr>
<td>Education</td>
<td>Idaho State Department of Education</td>
<td>Matt McCarter</td>
<td><a href="mailto:mamccarter@sde.idaho.gov">mamccarter@sde.idaho.gov</a></td>
</tr>
<tr>
<td>DHW-VS</td>
<td>Idaho DHW – Vital Statistics</td>
<td>Andy Bourne</td>
<td><a href="mailto:BourneA@dhw.idaho.gov">BourneA@dhw.idaho.gov</a></td>
</tr>
<tr>
<td>ISP</td>
<td>Idaho State Police</td>
<td>Janeena Wing</td>
<td><a href="mailto:Janeena.wing@isp.idaho.gov">Janeena.wing@isp.idaho.gov</a></td>
</tr>
<tr>
<td>Courts</td>
<td>Idaho Supreme Court</td>
<td>Scott Ronan</td>
<td><a href="mailto:sronan@idcourts.net">sronan@idcourts.net</a></td>
</tr>
</tbody>
</table>
Appendix B – Idaho state map with counties labeled
DIVISION OF BEHAVIORAL HEALTH
DIVISION OPERATIONS

Policy: Acuity & Level of Care

Effective Date: January 18, 2011
Exclusion: State Hospitals
Annual Review Date: January 18

Supersedes: N/A
Annual Reviewer: Central Office

Approved by: Division Administrator
Approved Date: 1/18/11

DBH Policy Number: 11-03
Technical Support Contact:
Behavioral Health Program Specialist, Central Office

Policy Rescinded by: N/A

Programs Affected: Adult Mental Health and Children’s Mental Health Programs
Locations: Statewide
Total Pages: 5
Attachment(s):
Adult Mental Health Acuity Matrix
Children’s Mental Health Acuity Matrix

1. INTRODUCTION:

The Division of Behavioral Health is committed to promoting and protecting the health and safety of Idahoans by ensuring that clinically necessary mental health and substance use disorder services are available through the State of Idaho to individuals who meet specific eligibility criteria.

2. BACKGROUND:

The Division of Behavior Health strives to provide consistent care to individuals receiving mental health services from the Department of Health and Welfare. The level of care needed and accessed is based on use of several assessment tools (e.g. Common Assessment, LOCUS/CALOCUS) and sound clinical judgment. Previously, no system or structure within the state captured or supported documenting this level of need and direct service staff efforts in a consistent manner. From this need emerged the Behavioral Health acuity rating scale; consumers in both Adult Mental Health and Children’s Mental Health are assigned an acuity based upon clinical needs: a) High; b) Moderate; & c) Low.

3. PURPOSE:

The purpose of this policy is to require an accurate acuity rating for all consumers in the adult and children’s mental health programs. An acuity rating is a consistent way to communicate the
general level of intervention provided to the consumer. The acuity rating will also direct the frequency of contact with the consumer, frequency of home visits, LOCUS/CALOCUS administrations, treatment plan reviews and additional program specific criterion. The three acuity levels outlined in this policy broadly categorize the clinical level of need and interventions being accessed by the consumer.

4. POLICY:

Upon completion of the Common Assessment, LOCUS/CALOCUS, and other program specific assessment tools, the Primary Care Staff shall meet with his or her supervisor or treatment team within ten (10) business days to establish the consumer’s acuity level for eligible and opened cases. Upon agreement with the supervisor, the Primary Care Staff shall document the acuity level in the Electronic Medical Record (EMR). Acuity determinations will be made at intake (see Intake Policy 11-07) and at each required 120 day review. The acuity level shall be updated if a significant change in the consumer circumstances or presentation occurs. Each assessment of acuity will be documented in the consumers EMR. Primary Care Staff shall be expected to maintain contact with the consumer as indicated in the attached program specific Acuity Matrix and documented in the EMR.

5. PROCEDURE:

The Primary Care Staff shall assign an acuity level following completion of the Common Assessment, LOCUS/CALOCUS and other program specific assessment tools. The level of acuity assigned by the Primary Care Staff shall be reviewed and approved by either the treatment team or by the supervisor and documented in the EMR within 10 days of completing the assessment. This determination will be based upon the level of service the consumer is provided, not the level of service that the consumer is identified as needing.

Assessment of acuity shall occur on the case at minimum every 120 days during the 120-day review or more frequently if a significant change in a client’s circumstance or presentation occurs. Each (re)assessment of acuity will be documented in the EMR.

Primary Care Staff are expected to maintain contact with consumers as indicated in Program Specific Acuity Matrix. These ongoing contacts shall be documented in the EMR. If a voluntary client does not wish to be contacted, the Primary Care Staff shall document each instance of this in the EMR.

6. OUTCOMES AND MONITORING:

Compliance with this policy will be monitored according to applicable policies and rules using information obtained through electronic data systems, interviews, paper documentation, on-site reviews, and/or other means, as needed. Information gathering and monitoring may be the responsibility of DBH central office, regional DBH programs, or both.

This policy and related outcomes will be reviewed for meaningfulness and applicability annually or more frequently, if indicated.
7. REFERENCES:

Common Assessment Policy 11-06
LOCUS and CALOCUS Policy 11-02
Intake Policy 11-07
## Adult Mental Health Program Acuity Matrix

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Level of Care</th>
<th>Face to Face Contact (at minimum)</th>
<th>Home Visits (at minimum)</th>
<th>Prescriber Visits</th>
<th>Common Assessment</th>
<th>LOCUS Assessment</th>
<th>Treatment Plan (reviews)</th>
<th>Fee Determination &amp; Benefit Elig. Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>High Intensity, programmed services</td>
<td>7 days</td>
<td>30 days</td>
<td>Per prescriber order</td>
<td>Annually or as needed</td>
<td>120 days or more often as needed</td>
<td>120 day review or more often as needed</td>
<td>Annually on anniversary date</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multi-system; extensive collaboration</td>
<td>30 days</td>
<td>As needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Maintenance, coordinated service(s)</td>
<td>120 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Children’s Mental Health Acuity Matrix

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Level of Care</th>
<th>Face to Face Contact (at minimum)</th>
<th>Home Visits (at minimum)</th>
<th>Common Assessment</th>
<th>CAFAS Assessment (after baseline)</th>
<th>CALOCUS Assessment (after baseline)</th>
<th>Treatment Plan (reviews)</th>
<th>Fee Determination &amp; Benefit Elig. Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>High Intensity, programmed services</td>
<td>30 days†</td>
<td>60 days</td>
<td>120 days</td>
<td>30 days or more often if needed</td>
<td></td>
<td>120 day review or more often as needed</td>
<td>Annually on anniversary date</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multi-system; extensive collaboration</td>
<td>30 days</td>
<td>90 days</td>
<td>Annually or as needed</td>
<td>120 days</td>
<td></td>
<td>120 days or more often as needed</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Maintenance, coordinated service(s)</td>
<td>120 days</td>
<td>365 days</td>
<td>120 days</td>
<td>120 days or more often as needed</td>
<td></td>
<td>120 day review or more often as needed</td>
<td></td>
</tr>
</tbody>
</table>

† Verbal contact with child and or family every 7 days
1. INTRODUCTION:

The Division of Behavioral Health is committed to promoting and protecting the health and safety of Idahoans by ensuring that clinically necessary mental health and substance use disorder services are available throughout the State of Idaho to individuals meeting eligibility criteria.

2. BACKGROUND:

Ongoing case review is a mechanism to ensure Division of Behavioral Health consumers receive services that are clinically necessary, effective, and provided in accordance with rules, policies, and practice standards.

3. PURPOSE:

This policy provides direction on the review of Adult Mental Health and Children’s Mental Health cases to ensure compliance with Department of Health and Welfare and Division of Behavioral Health rules, policies, and best practice standards.

4. POLICY:

The Quality Assurance Program within the Division of Behavioral Health will review Adult Mental Health and Children’s Mental Health cases in each region every other quarter. The Continuous Quality Improvement (CQI) instrument will be used to measure regional compliance. Results, in the form of a written report, will be provided to the Hub Operations Administrator and the regional Program Manager. If required, the regional Program Manager will submit and
implement an approved corrective action plan addressing areas found not in compliance with rules, policies, and practice standards.

5. PROCEDURE:

The Quality Assurance Program Manager will designate a team member(s) to review Children’s Mental Health and Adult Mental Health cases in each region, every other quarter. The number of cases to be reviewed will be determined at the time of review. Cases to be reviewed may be chosen at random or may be selected specifically from cases open the last day of the quarter preceding the quarter of the review. The designated Quality Assurance team member(s) will complete the applicable CQI Case Review Instrument using information from one or a combination of the following:

- the program’s information system
- the case file
- the assigned clinician or their supervisor
- interview(s) with family members, guardians, treatment providers, or other involved parties.

At the regional Program Manager’s discretion, regional staff will be invited to assist in conducting on-site case reviews. At the conclusion of the case reviews, a verbal summary of preliminary findings will be presented. Regional staff may be invited to attend at the discretion of the regional Program Manager.

Within ten (10) business days of the case review, the lead Quality Assurance team member will provide those participating in conducting the CQI review with a draft report of findings and the opportunity to provide input on the report. Within ten (10) business days of providing the draft report to those participating in conducting the review, the lead Quality Assurance team member will provide a final written report of the review findings to the central office Quality Assurance Program Manager, Hub Administrator, and regional Program Manager.

The regional Hub Operations Administrator and/or Program Manager and the lead Quality Assurance team member will negotiate a Corrective Action Plan (CAP) and finalize the CAP within ten (10) business days of the date the final report is received by the region. The CAP will document the following for each area identified as not in compliance with rules, policies, and practice standards:

- action to correct issues found not in compliance
- anticipated date of completing the corrective action
- action to prevent recurrence
- name and title of the staff person responsible for implementation and completion of the CAP.

The lead Quality Assurance team member will accept or negotiate modifications to the regional CAP within ten (10) business days of receipt. The finalized CAP will be implemented by the regional Program Manager.
If a CQI review identifies an area as not in compliance with rules, policies, or a practice standard that was to be addressed in a previous CAP, the Quality Assurance Program Manager may direct corrective action.

6. OUTCOMES AND MONITORING:

Compliance with this policy will be monitored according to applicable policies and rules using information obtained through electronic data systems, interviews, paper documentation, on-site reviews, and/or other means, as needed. Information gathering and monitoring may be the responsibility of DBH central office, regional DBH programs, or both.

This policy and related outcomes will be reviewed for meaningfulness and applicability annually or more frequently, if indicated.

7. REFERENCES:

Children’s Mental Health CQI Case Review Instrument and Instructions  
Idaho Code, Title 16, Chapter 24 – Children’s Mental Health Services  
IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits  
IDAPA 16.07.33 – Adult Mental Health Services  
IDAPA 16.07.37 – Children’s Mental Health Services  
DHW Customer Service Standards  
DHW Strategic Plan 2007-2011 Goal #3 – “Enhance the Delivery of Health and Human Services.”
1. INTRODUCTION:

The Division of Behavioral Health is committed to eliminating cultural and linguistic barriers, and promoting convenient service access. The Division supports service delivery that is respectful of and responsive to the beliefs, practices, and cultural needs of those we serve.

2. BACKGROUND:

The Department of Health and Welfare encourages its employees to understand, value, and incorporate the cultural differences of Idaho’s diverse population in order to more appropriately respond to and serve the unique needs of the culturally different populations. Spanish is the most common foreign language spoken in Idaho. The Knowledge and Learning Center (KLC) has courses on Cultural Diversity and Cultural Issues in Mental Health Treatment for all staff providing direct services.

3. PURPOSE:

This policy describes Department expectations and available training resources on cultural competency and ways to eliminate cultural and linguistic barriers in order to improve client satisfaction, reduce treatment and statistical error, reduce communication breakdown, and improve overall respect for those from divergent cultures.
4. POLICY:

All Division staff shall provide services in an effective, understandable, and respectful manner. Service delivery will be compatible with the cultural beliefs, practices, and preferred language of those being served.

5. PROCEDURE:

Knowledge and Learning Center Course:
All Division staff who provide direct services shall complete the KLC Cultural Diversity course and the Cultural Issues in Mental Health Treatment course within the first month of hire, then again a minimum of once every three years after that. Supervisors shall maintain documentation of this in each staff member’s personnel file.

Language Assistance:
At the front desk or entrance of every regional office, state hospital, and Central office, signs shall be posted in the top several languages, explaining to consumers, ways to indicate which foreign language they speak, and their right to receive language assistance services.

Each regional office, state hospital, and Central Office shall maintain and update the Departments’ Directory of Communication Resources for approved interpreters.
All Staff will follow the Procedures for Obtaining Interpreter and Translation Services.

At the front desk or entrance of each field office, state hospital, and Central Office, Support staff, or designee, shall make frequently used forms available in the most common foreign languages, for persons with limited English speaking ability.

If a client has a grievance or complaint, the Division shall provide a bilingual staff to interpret during the complaint/grievance process, using the Procedures for Obtaining Interpreter and Translation Services.

Accurate Data Input:
All Division staff tasked with duties of inputting data, shall record the client’s race, ethnicity, as well as their choice of spoken and written language if it is not English. This will be used when sending out client satisfaction surveys, as well as language preference in which they prefer to fill out any relevant forms. Documents created as part of the treatment process (including assessments, treatment plans, etc.) can also be translated as requested by consumers and families.

Questions regarding cultural sensitivity and awareness shall be part of the consumer satisfaction surveys. Support staff shall check each client’s written language preference before mailing out any client satisfaction survey to that individual.

Demographic Status Maintenance:
The Division shall implement strategies to recruit, retain, and promote at all levels of the organization, a diverse staff and leadership that represents the demographic characteristics of the service area.
The Program Manager shall maintain a current demographic and cultural profile of the community. The Program Manager may request additional resources as demonstrated by a change in the demographics of the community being served.

6. OUTCOMES AND MONITORING:

Supervisor will monitor individual staff compliance with this policy through completion of training requirements, addressing consumer complaints, survey feedback, and failure to follow procedures. Supervisors will work with staff to follow this policy if issues arise. Overall Division compliance will be measured by Quality Assurance specialists, programmatic reviews, and individual case reviews.

7. REFERENCES:

- National Standards on Culturally and Linguistically Appropriate Services
- Department Non-Discrimination Statement
- InfoNet:
  - Directory of Interpreter/Communication Resources
  - Procedure for Obtaining Interpreter and Translation Services
DIVISION OF BEHAVIORAL HEALTH

1. INTRODUCTION:

The Division of Behavioral Health is committed to promoting and protecting the health and safety of Idahoans by ensuring that clinically necessary mental health and substance use disorder services are available through the State of Idaho to individuals who meet specific eligibility criteria.

2. BACKGROUND:

Ongoing review of cases is a mechanism to ensure Division of Behavioral Health consumers receive services that are clinically necessary, effective, and provided in accordance with rules, policies, and best practice standards.

3. PURPOSE:

This policy provides direction on the structure of Regional Quality Management Teams and the responsibilities of Regional Quality Management Teams in conducting quality improvement reviews to ensure ongoing monitoring and improvement in the provision of public mental health services.

4. POLICY:

QUALITY ASSURANCE is composed of five (5) primary areas:
- Quality Management Team Structure and Responsibilities;
- Quality Assurance (QA)/Continuous Quality Improvement (CQI) Case Reviews;
- Corrective Action;
- Performance Improvement; and

Quality Assurance Effective Date: January 21, 2011 Page: 1
• Stakeholder Review Systems

Each of the five (5) Quality Assurance areas requires involvement at the local and statewide level. On the local level, each region will be responsible for the implementation of Quality Assurance processes. On the statewide level, central office will provide leadership and direction to the local entities or regions.

REGIONAL QUALITY MANAGEMENT TEAM COMPOSITION AND RESPONSIBILITIES

Each region shall establish and maintain a Regional Quality Management Team (RQMT). The RQMT will provide regional leadership for all areas of the QM policy and system. The composition of the regional QM Team is as follows:

- Behavioral Health Program Manager
- Adult Mental Health Supervisors
- Children’s Mental Health Chief
- Medical Representative (i.e., physician, nurse, mid-level prescriber)
- Administrative Support representative
- Direct Service Staff representative (i.e., clinician, social worker, PSR worker)

The QMT will meet every quarter, at a minimum. The QMT responsibilities/duties include:

- Reviewing results of records reviews and determining internal solutions for deficiencies
- Reviewing and responding to complaints (See Complaint Resolution Policy 11-10)
- Reviewing and responding to adverse outcomes/incidents (see Incident Report Policy)
- Utilization reviews
- Customer satisfaction survey results
- Facilities and Operations
- Review WITS reports for practice implications
- Review trend data and implement strategies based on what the data demonstrates

These duties should be standing agenda topics for the QMT quarterly meetings.

The Division of Behavioral Health’s Leadership Team will serve as the statewide QMT. The duties for the statewide QMT will be the same as listed above, but focused on statewide data, trends, and practices.

5. PROCEDURE:

QUALITY ASSURANCE/CONTINUOUS QUALITY IMPROVEMENT REVIEWS

Quality Assurance (QA)/Continuous Quality Improvement (CQI) case reviews are a critical component of the QM system. QA/CQI case reviews will be broken into two (2) segments. The first segment is a quantitative, or compliance related, medical records review. The second is a qualitative review that will look at client progress, clinical decisions, outcomes, etc. The qualitative and quantitative reviews should be viewed as sister documents completed in concert with one another. The
procedures for the quantitative and qualitative reviews will be outlined in the instructions that accompany the instrument. Reviews will be completed by Regional QMT twice yearly. The Quality Assurance/Utilization (QA/U) Program Manager will provide oversight of the process. The QA/U Manager/Central Office QA Staff will participate in the reviews periodically to ensure inter-rater reliability.

The regional QMT will coordinate the review process in each region. All regional clinical staff, supervisors, and regional management will be in the pool for completing regional reviews and should have the opportunity to participate in the reviews on a rotating basis. However, no staff should review their own case and reviews should be completed in teams of two or more. The Regional QMT will be responsible to review a one case per staff member per region of open CMH case and one case per staff member per region of open AMH cases, selected randomly, twice a year. The directions for random selection will be outlined in the instructions that accompany the instrument. The completed instruments and a report summarizing the results will be provided to the QA/U Program Manager within 30 calendar days of the end of each review period. The regional reviews will be completed during the first and third quarters of the fiscal year. The second and fourth quarters will be utilized for corrective action. The reviews will focus on three (3) months of activity call the Period Under Review (PUR). The PUR will be the three (3) months prior to the quarter in which the reviews are completed.

Central office will conduct reviews upon mutual consent of the Hub Operations Administrator and the QA/U Program Manager. The central office reviews will utilize the standard qualitative and quantitative review instruments or may include more focused/specialized reviews in particular areas of interest. The focus of the Central Office reviews will be based on regional needs and identified areas of concern.

CORRECTIVE ACTION

Corrective Action is the process that will be utilized to correct any areas identified through the regional or central office reviews as deficient. If the results of the regional or central office review demonstrate a lack of substantial compliance in a particular area, the QA/U Program Manager will request a corrective action plan from the region for each area of deficiency. The first time an area is identified as deficient, the corrective action plan will be developed and completed by the region and reported to the QA/U Program Manager. If an area lacks substantial compliance in two (2) consecutive reviews, the corrective action plan will be developed by the QA/U Program Manager in collaboration with the Hub Operations Administrator and executed by the QMT under the oversight of the QA/U Program Manager. If a region has achieved substantial compliance for two (2) consecutive reviews, they may be permitted to skip the next regional and central office reviews. The corrective action format will be provided by central office.

PERFORMANCE IMPROVEMENT

The QMT will be responsible to develop two (2) performance improvement goals per year under the direction and guidance of the Hub Operations Administrator. The QMT will utilize data to determine areas that need improvement in regional business processes, client outcomes, client satisfaction, etc. The QMT will develop a plan with timelines and measures to implement the plan. The progress toward meeting the performance improvement goal will be discussed at each of the quarterly QMT meetings.
meetings and the Regional Program Manager will present the goal, plan, and progress at the monthly/bi-monthly Division of Behavioral Health Leadership Team meetings. Following the completion of the project, a report on the performance improvement goal, including project description, measures, and results will be developed and distributed to all Leadership Team members and the QA/U Manager. This report is due within 30 calendar days of project completion.

**STAKEHOLDER REVIEW SYSTEMS**

Stakeholder Review Systems provide input and feedback on the mental health system and should be considered in decision making. Several stakeholder review systems are currently in place. QMT shall collect and utilize stakeholder information when considering performance improvement goals. Some of the Stakeholder Review Systems include:

- State Planning Council on Mental Health
- Region Mental Health Boards
- Consumers/Families
- Consumer/Family Advocacy Organizations
- State and Local Correction Agencies
- Courts
- Vocational Rehabilitation
- Education
- Communities

6. **OUTCOMES AND MONITORING:**

Compliance with this policy will be monitored according to applicable policies and rules using information obtained through electronic data systems, interviews, paper documentation, on-site reviews, and/or other means, as needed. Information gathering and monitoring may be the responsibility of DBH central office, regional DBH programs, or both.

This policy and related outcomes will be reviewed for meaningfulness and applicability annually or more frequently, if indicated.

7. **REFERENCES:**

Idaho Code, Title 16, Chapter 24 – Children’s Mental Health Services
IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits
IDAPA 16.07.37 – Children’s Mental Health Services
DHW Customer Service Standards
DHW Strategic Plan 2007-2011 Goal #3 – “Enhance the Delivery of Health and Human Services.”
IDAPA 16.07.33 – Adult Mental Health Services
## MEDICAID REQUIREMENTS (IDAPA 16.07.20, Section 09.01 and DHW QSUDP List)

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>Score/Possible</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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</tr>
<tr>
<td>All Levels of Care</td>
<td>Criminal History and Background Check. All owners, operators, employees, transfers, reinstated former employees, student interns, contractors and volunteers hired or contracted with after May 1, 2010, who provide direct care or service or have direct client access, must comply with the provisions of IDAPA 16.05.06 “Criminal History and Background Checks.”</td>
<td>0</td>
</tr>
<tr>
<td>Do all of the clinicians providing a Medicaid reimbursable service under Medicaid funding have a DHW Cleared Criminal History &amp; Background Check?</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

| 2         |                |          |
| All Levels of Care | Clinician providing any Medicaid reimbursable service is listed on the DHW website as a QSUDP. The website listing is as follows; | 0 | 0 | TOTAL-Medicaid Requirements |
| Are all of the clinicians providing a Medicaid reimbursable service under Medicaid funding listed on the DHW website as a QSUDP? | 0 | 0 | |

## CLIENT RIGHTS (IDAPA 16.07.20 Section 350.01-.08)

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>Score/Possible</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Levels of Care</td>
<td>All alcohol and substance disorders treatment or recovery support services program must have written policies and procedures to protect the fundamental human, civil, constitutional, and statutory rights of each client.</td>
<td>0</td>
</tr>
<tr>
<td>Have all of the IDAPA items .01 to .08 been documented in each client's record?</td>
<td>0</td>
<td>0</td>
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</table>

## CLIENT RECORDS (IDAPA 16.07.20, Section 375.03 & 04)

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>Score/Possible</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>4</td>
<td></td>
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<tr>
<td>All Levels of Care</td>
<td>Assessments Completed With the Client. All assessments completed with the client must be dated, signed by the person providing the assessment, and give a full accounting of the findings of such assessments.</td>
<td>0</td>
</tr>
<tr>
<td>Has this been documented in the client's record as applicable?</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Progress Notes. Notes for each treatment session charting the client's progress must include:
- Date of session;
- Beginning and ending time of session;
- Description of the session;
- Signature of person conducting the session;
- All staffing notes pertaining to the client;
- All medical records regarding the client. These may include documentation of a medical examination, results of any medical tests, including drug and alcohol screening tests performed by the program, and results of any medical tests reported to the program which were performed outside the program; and
- Documentation that justifies the client meets criteria for admission, continued stay, and discharge. The documentation must be based on admission, continued stay and discharge criteria approved by the Department.

<table>
<thead>
<tr>
<th>All Levels of Care</th>
<th>Have progress notes been documented for SUD billable services in the client's record as applicable?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 0</td>
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</table>

<table>
<thead>
<tr>
<th>Residence Only</th>
<th>Timeline for Development of the Treatment Plan. A treatment plan must be developed within seventy-two (72) hours following admission to an inpatient or residential facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Has the treatment plan been developed within 72 hours?</td>
</tr>
<tr>
<td></td>
<td>0 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Only</th>
<th>Timeline for Development of the Treatment Plan. A treatment plan must be developed within thirty (30) days of the completion of a state approved assessment in an outpatient setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Has the treatment plan been developed within 30 days?</td>
</tr>
<tr>
<td></td>
<td>0 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Only</th>
<th>The treatment plan must be updated at least every ninety (90) days in an outpatient setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Are documented updates occurring at least every ninety (90) days?</td>
</tr>
<tr>
<td></td>
<td>0 0</td>
</tr>
<tr>
<td>Level</td>
<td>Requirement</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>10</strong></td>
<td>Discharge Plan. A discharge plan must be jointly developed by the qualified substance use disorders professional and the client. This discharge plan includes the resources needed to support their recovery.</td>
</tr>
<tr>
<td><strong>11</strong></td>
<td>The discharge plan must be initiated within forty-eight (48) hours of admission to a residential program and completed prior to the conclusion of substance use disorders treatment and recovery support services.</td>
</tr>
<tr>
<td><strong>12</strong></td>
<td>Has this been documented in the client's record if they were attending residential services?</td>
</tr>
<tr>
<td><strong>13</strong></td>
<td>A hard copy of the discharge plan must be given to the client at the time of discharge from treatment.</td>
</tr>
<tr>
<td><strong>14</strong></td>
<td>Has this been documented in the client's record if they were attending an outpatient level of care?</td>
</tr>
<tr>
<td><strong>15</strong></td>
<td>The discharge plan must be initiated within thirty (30) days of admission to an outpatient program and completed prior to the conclusion of substance use disorders treatment and recovery support services.</td>
</tr>
<tr>
<td></td>
<td>Has this been documented in the client's record if they were attending an outpatient level of care?</td>
</tr>
<tr>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>16</td>
<td>A hard copy of the discharge plan must be given to the client at the time of discharge from treatment. Has this been documented in the client's record if they were attending an outpatient level of care?</td>
</tr>
<tr>
<td>17</td>
<td>The discharge plan must include: a. The recovery support services and adjunct services to be continued after discharge including the location and contact information of existing appointments; b. Information about accessing resources to maintain gains achieved while in treatment; c. Identification of stressors that may lead to a return to the use of alcohol or drugs and methods to address the stressors; and d. Identification of person(s) to contact if additional services are needed. Has this been documented in the client's record if they were attending an outpatient level of care?</td>
</tr>
<tr>
<td>18</td>
<td>Discharge Summary. A discharge summary must be entered in the client record within fifteen (15) days following discharge, as follows; a. The discharge summary must include the results of the initial assessment and diagnosis. b. The discharge summary must include a clinical summary of the following: i. The course and progress of the client with regard to each identified clinical problem; ii. The clinical course of the client’s treatment; iii. The final assessment, including the general observations and understanding of the client's condition initially, during treatment and at discharge; and iv. The recommendations and arrangements for further treatment as described in the discharge plan. Has this been documented in the client's record if applicable?</td>
</tr>
</tbody>
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**CLINICAL CASE MANAGEMENT (IDAPA 16.07.20, Section 455.01)**

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<table>
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<tbody>
<tr>
<td>19</td>
<td>Clinical Case Management Services. a. Services must include a full biopsychosocial assessment, utilizing a Department-approved assessment tool, and a case-management assessment of the client and client family strength and needs, service planning, linkage to other services, client advocacy, and monitoring service provisions. Have all of the above conditions been met and documented in the client's Comprehensive Service Plan?</td>
<td>0 0</td>
</tr>
</tbody>
</table>

---
Clinical Case Manager Qualifications.

a. A clinical case manager must be a Masters-level licensed clinician and be a qualified substance use disorders professional as defined in Section 013 of these rules.

| All Levels of Care |  
|-------------------|---
| Does the clinician providing Clinical Case Management services meet both requirements? | 0 0 0 0 |

**BPA CONTRACTUAL REQUIREMENTS**

<table>
<thead>
<tr>
<th>20</th>
<th>All Levels of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Is there a Master Problem List in the client record?</td>
</tr>
<tr>
<td>21</td>
<td>Is there a Treatment Plan for each problem identified on the problem list that is not either deferred or referred?</td>
</tr>
<tr>
<td>22</td>
<td>For Discharged clients is there a completed Client Services Discharge form in the file within 30 days of last billable service?</td>
</tr>
</tbody>
</table>

**Comments:**
<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>BPA REQUIREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is the client's name and state or agency identifier on all audited dates of service.</td>
</tr>
</tbody>
</table>

**REFERRALS FOR TESTING (mandatory for IV drug users according to the Federal Block Grant).**

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>BPA REQUIREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>There is documentation that the client was given a referral or information regarding HIV testing.</td>
</tr>
<tr>
<td>3</td>
<td>There is documentation that the client was given a referral or information regarding TB testing.</td>
</tr>
</tbody>
</table>

**CLIENT RELEASE**

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>BPA REQUIREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Does the client record include a completed Confidentiality Agreement with 42 CFR 2?</td>
</tr>
<tr>
<td>5</td>
<td>Does the client record include a completed DHMV release of information form, no blank lines and is signed? (If the client is an adolescent, under 16, a parent or guardian has to sign the release).</td>
</tr>
<tr>
<td>6</td>
<td>Does the client record include completed Release of Information forms? (Not to include DHMV release as listed above in indicator #4).</td>
</tr>
</tbody>
</table>

**GENERAL TREATMENT PLAN DOCUMENTATION**

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>BPA REQUIREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Individualized Treatment Plan. A state-approved alcohol and substance use disorder treatment program must prepare for each client an individualized treatment plan that addresses the alcohol or substance use and co-occurring mental health disorders health affects on the client's major life areas. The development of a treatment plan must be a collaborative process involving the client, family members, and other support and service systems.</td>
</tr>
<tr>
<td>Content of the Treatment Plan. The individualized treatment plan must include the following:</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>a. The services deemed clinically necessary to facilitate the client's alcohol and substance use disorders recovery;</td>
<td></td>
</tr>
<tr>
<td>b. Referrals for needed adjunct services that the alcohol and substance use disorders treatment program does not provide.</td>
<td></td>
</tr>
<tr>
<td>c. Referrals for recovery support services that support treatment as defined in Subsection 012.03 of these rules;</td>
<td></td>
</tr>
<tr>
<td>d. Goals that the client must complete to reduce or eliminate alcohol or substance use and support recovery;</td>
<td></td>
</tr>
<tr>
<td>e. Objectives that relate to the goals, written in measurable terms, with targeted expected achievement dates;</td>
<td></td>
</tr>
<tr>
<td>f. Service frequency;</td>
<td></td>
</tr>
<tr>
<td>g. Criteria to be met for discharge from treatment; and</td>
<td></td>
</tr>
<tr>
<td>h. A plan for including the family or other social supports.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Integrated COD Treatment Plan Development. In addition to the information in Section 380.05 of this section, the individualized treatment plan for a client with a co-occurring disorder must address the COD treatment and recovery support service needs of the client as identified in the current assessment. These additional items include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. A list of COD problems and needs identified during the assessment;</td>
</tr>
<tr>
<td>b. Overall goals to be achieved consistent with the client's treatment and recovery support services needs and assessment;</td>
</tr>
<tr>
<td>c. Reference to all services and contributions provided by the informal support system;</td>
</tr>
<tr>
<td>d. Documentation of who participated in the selection of services;</td>
</tr>
<tr>
<td>e. Documentation of unmet needs and service gaps;</td>
</tr>
<tr>
<td>f. References to any formal services arranged including specific providers;</td>
</tr>
<tr>
<td>g. Time frames for achievement of the treatment plan goals and objectives.</td>
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</tbody>
</table>

| Client record indicates collateral contacts made or received on behalf of the client. |
### SUPERVISION/STAFFING

<p>| | |</p>
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<tbody>
<tr>
<td>11</td>
<td>All clinical documentation completed by a QSUDPT must be countersigned by a QSUDP. Treatment Supervisor or Clinical Supervisor until the QSUDPT is approved as a QSUDP. The signature of the Clinical Supervisor/Supervising Clinician indicates attendance in the session with the Trainee if signed and dated the same date as the service provided. If signed and dated with a later date it is indicating the Trainee provided service on their own.</td>
</tr>
<tr>
<td>12</td>
<td>The client record documents that their case is staffed with the clinician and clinical supervisor. The clinical staffing note reflects ASAM criteria as indicated by the client’s need, but shall not be less often than every 90 days in an outpatient facility and no less than every 14 days in a residential facility.</td>
</tr>
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### RECOVERY SUPPORT SERVICES

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<table>
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<tbody>
<tr>
<td>13</td>
<td>Clinical notes record evaluation of need for Recovery Support Services (RSS) and other ancillary services as explained on the RSS Evaluation Form.</td>
</tr>
<tr>
<td>14</td>
<td>Client record documents referrals made to RSS and other ancillary services as indicated in the evaluation process and/or form.</td>
</tr>
</tbody>
</table>

### ADOLESCENTS ONLY

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<tbody>
<tr>
<td>15</td>
<td>There is documentation of parental/caregiver involvement or attempt to obtain parental/caregiver involvement in the adolescent’s chart.</td>
</tr>
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</table>

### CRIMINAL JUSTICE (includes IDOC and Drug Court clients only)

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<table>
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<tbody>
<tr>
<td>16</td>
<td>The client record indicates the clinician is communicating with correctional staff in situations where the client is on supervised probation or parole at both the state and county level. A release of information is necessary as applicable by law.</td>
</tr>
<tr>
<td>Category</td>
<td>Service/Activity Example</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Healthcare Home/Physical Health</td>
<td>• General and specialized outpatient medical services</td>
</tr>
<tr>
<td></td>
<td>• Acute Primary Care</td>
</tr>
<tr>
<td></td>
<td>• General Health Screens, Tests and Immunization</td>
</tr>
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<td></td>
<td>• Comprehensive Care Management</td>
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<td></td>
<td>• Care coordination and health promotion</td>
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<tr>
<td></td>
<td>• Comprehensive transitional care</td>
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<td></td>
<td>• Individual and Family Support</td>
</tr>
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<td></td>
<td>• Referral to Community Services</td>
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<tr>
<td>Engagement Services</td>
<td>• Assessment</td>
</tr>
<tr>
<td></td>
<td>• Specialized Evaluation (Psychological and neurological)</td>
</tr>
<tr>
<td></td>
<td>• Services planning (includes crisis planning)</td>
</tr>
<tr>
<td></td>
<td>• Consumer/Family Education</td>
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<tr>
<td></td>
<td>• Outreach</td>
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<tr>
<td>Outpatient Services</td>
<td>• Individual evidence-based therapies</td>
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<td></td>
<td>• Group therapy</td>
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<tr>
<td></td>
<td>• Family therapy</td>
</tr>
<tr>
<td></td>
<td>• Multi-family therapy</td>
</tr>
<tr>
<td></td>
<td>• Consultation to Caregivers</td>
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<tr>
<td>Medication Services</td>
<td>• Medication management</td>
</tr>
<tr>
<td></td>
<td>• Pharmacotherapy (including MAT)</td>
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<tr>
<td></td>
<td>• Laboratory services</td>
</tr>
<tr>
<td>Community Support (Rehabilitative)</td>
<td>• Parent/Caregiver Support</td>
</tr>
<tr>
<td></td>
<td>• Skill building (social, daily living, cognitive)</td>
</tr>
<tr>
<td></td>
<td>• Case management</td>
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<tr>
<td></td>
<td>• Behavior management</td>
</tr>
<tr>
<td></td>
<td>• Supported employment</td>
</tr>
<tr>
<td></td>
<td>• Permanent supported housing</td>
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<tr>
<td></td>
<td>• Recovery housing</td>
</tr>
<tr>
<td></td>
<td>• Therapeutic mentoring</td>
</tr>
<tr>
<td></td>
<td>• Traditional healing services</td>
</tr>
<tr>
<td>Recovery Supports</td>
<td>• Peer Support</td>
</tr>
<tr>
<td></td>
<td>• Recovery Support Coaching</td>
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<tr>
<td></td>
<td>• Recovery Support Center Services</td>
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<td></td>
<td>• Supports for Self Directed Care</td>
</tr>
<tr>
<td>Other Supports</td>
<td>• Personal care</td>
</tr>
<tr>
<td>Category</td>
<td>Service/Activity Example</td>
</tr>
<tr>
<td>--------------------------------</td>
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<tr>
<td>(Habilitative)</td>
<td>• Homemaker</td>
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<td></td>
<td>• Respite</td>
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<tr>
<td></td>
<td>• Supported Education</td>
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<tr>
<td></td>
<td>• Transportation</td>
</tr>
<tr>
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<td>• Assisted living services</td>
</tr>
<tr>
<td></td>
<td>• Recreational services</td>
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<tr>
<td></td>
<td>• Interactive Communication Technology Devices</td>
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<tr>
<td></td>
<td>• Trained behavioral health interpreters</td>
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<td>Intensive Support Services</td>
<td>• Substance abuse intensive outpatient services</td>
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<tr>
<td></td>
<td>• Partial hospitalization</td>
</tr>
<tr>
<td></td>
<td>• Assertive community treatment</td>
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<td></td>
<td>• Intensive home based treatment</td>
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<td></td>
<td>• Multi-systemic therapy</td>
</tr>
<tr>
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<td>• Intensive case management</td>
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<tr>
<td>Out-of-Home Residential Services</td>
<td>• Crisis residential/stabilization</td>
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<td></td>
<td>• Clinically Managed 24-Hour Care</td>
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<tr>
<td></td>
<td>• Clinically Managed Medium Intensity Care</td>
</tr>
<tr>
<td></td>
<td>• Adult Mental Health Residential</td>
</tr>
<tr>
<td></td>
<td>• Adult Substance Abuse Residential</td>
</tr>
<tr>
<td></td>
<td>• Children’s Mental Health Residential Services</td>
</tr>
<tr>
<td></td>
<td>• Youth Substance Abuse Residential Services</td>
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<tr>
<td></td>
<td>• Therapeutic Foster Care</td>
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<td>Acute Intensive Services</td>
<td>• Mobile crisis services</td>
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<td></td>
<td>• Medically Monitored Intensive Inpatient</td>
</tr>
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<td>• Peer based crisis services</td>
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<td>• Urgent care services</td>
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<td>• 23 hour crisis stabilization services</td>
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<td>• 24/7 crisis hotline services</td>
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<tr>
<td>Prevention (Including Promotion)</td>
<td>• Screening, Brief Intervention and Referral to Treatment</td>
</tr>
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<td></td>
<td>• Brief Motivational Interviews</td>
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<td>• Screening and Brief Intervention for Tobacco Cessation</td>
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<td>• Parent Training</td>
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<td></td>
<td>• Facilitated Referrals</td>
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<td></td>
<td>• Relapse Prevention /Wellness Recovery Support</td>
</tr>
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<td></td>
<td>• Warm line</td>
</tr>
<tr>
<td>Category</td>
<td>Service/Activity Example</td>
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<td>System improvement activities</td>
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</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes:**
August 22, 2011

Mr. Ross Edmunds, Administrator
Division of Behavioral Health
Idaho Department of Health and Welfare
P O Box 83720
Boise, ID 83702-0036

Dear Mr. Edmunds,

As the Division of Medicaid we are supportive of the 2012-2103 Combined Mental Health and Substance Abuse Block Grant. As you have described, the Block Grant goals of promoting improved services and implementing Evidence-Based Practices for youth with emotional and behavioral disturbances, adults with serious mental illnesses, substance abuse issues, and/or co-occurring disorders are in line with our Division goals. We look forward to partnering with your Division to implement the Block Grant goals in the upcoming years.

Many collaborative efforts already exist between our two Divisions. The Division of Behavioral Health has participated in several Medicaid workgroups to improve the Medicaid mental health benefits package based upon client need. The Division of Medicaid collaborates with the Division of Behavioral Health’s State Mental Health Authority and Single State Authority in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the Medicaid population. The Division of Behavioral Health is the Medicaid provider for Substance Use Disorder treatment services in Idaho, and these services are managed through a contract with Business Psychology Associates. The Division of Medicaid contracts with private providers for delivery of mental health services to Idaho children and adults. The Divisions are collaborating with consumers and other state agencies for the “Money Follows the Person” Home Choice Program. As of July 2011, Medicaid is pursuing a contract with a managed care organization (MCO) with a target implementation date of July 1, 2012, for the administration of mental health benefits. The Division of Behavioral Health is providing input into the request for proposal for the managed care contract.

The Division of Medicaid appreciates the opportunities to collaborate with the Division of Behavioral Health and hopes to continue to partner toward achieving the Block Grant goals and future efforts to implement the identified behavioral health transformation plan.

Sincerely,

[Signature]
PAUL J. LEARY
Administrator

PJL/ksl
### FFY 2013 Application

**Date Range 7/1/2011 to 6/30/2012**

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Block Grant</th>
<th>B. Medicaid (Federal, State, and Local)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Substance Abuse Prevention* and Treatment</td>
<td>#REF!</td>
<td>#REF!</td>
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<tr>
<td>2 Primary Prevention</td>
<td>#REF!</td>
<td></td>
</tr>
<tr>
<td>3 Tuberculosis Services</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>4 HIV Early Intervention Services</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>5 State Hospital</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>6 Other 24 Hour Care</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>7 Ambulatory/Community non-24 hour care</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>8 Administration: Excluding Program/Provider</td>
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<td>#REF!</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>#REF!</td>
<td>#REF!</td>
</tr>
</tbody>
</table>

**Notes & Assumptions:**

12 Month Period includes: Actual State Fiscal Year 2011 Expenditures 7/1/10-6/30/11

Projected Expenditures for State Fiscal Year 2012 (7/1/11-6/30-12) are not currently available due to a recent SAPT reappropriation within the State System Administration Block Grant A.8. includes $366,527 used for Resource Development.

State Hospitals are not Funded by Block Grant and not included in the above. Additional information is available upon request.
### TABLE 7 SAPT

<table>
<thead>
<tr>
<th></th>
<th>C. Other federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>D. State Funds</th>
<th>E. Local Funds (excluding Local Medicaid)</th>
<th>F. Other</th>
<th>Total</th>
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<tbody>
<tr>
<td>#REF!</td>
<td>#REF!</td>
<td>$ 3,232,900</td>
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<tr>
<td>$ 981,465</td>
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</table>

Projected Expenditures for State Fiscal Year 2012 (7/1/11–6/30–12) are not currently available due to a recent SAPT reappropriation within the State System.

Additional information is available upon request.
### FFY 2013 Application

**Date Range**: 7/1/2011 to 6/30/2012

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Block Grant</th>
<th>B. Medicaid (Federal, State, and Local)</th>
<th>C. Other federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>D. State Funds</th>
<th>E. Local Funds (excluding Local Medicaid)</th>
<th>F. Other</th>
<th>Total</th>
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<tbody>
<tr>
<td>Substance Abuse Prevention* and Treatment</td>
<td>$ 1,160,937</td>
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<td>$ 2,444,973</td>
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<td></td>
<td>$ 23,947,958</td>
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<tr>
<td>Primary Prevention</td>
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<td></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Tuberculosis Services</td>
<td>$ -</td>
<td></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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<td>$ -</td>
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<tr>
<td>HIV Early Intervention Services</td>
<td>$ -</td>
<td></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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<tr>
<td>State Hospital</td>
<td>$ -</td>
<td></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Other 24 Hour Care</td>
<td>$ -</td>
<td></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Ambulatory/Community non-24 hour care</td>
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<td>$ 369,406</td>
<td>$ 246,993</td>
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<td>$ 706,746</td>
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<tr>
<td>Administration: Excluding Program/Provider</td>
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<td></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ 1,251,285</td>
<td></td>
<td>$ 2,814,379</td>
<td>$ 20,589,040</td>
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<td></td>
<td>$ 24,654,704</td>
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</tbody>
</table>

**Notes & Assumptions:**

Line #1 of the above table reflects CMHS Expenditures, NOT SAPT.

Actual State Fiscal Year 2011 Expenditures 7/1/10-6/30/11. The above only reflects a 12 month expenditure period consistent with the other tables provided.

Projected Expenditures for State Fiscal Year 2012 are not included above, but are expected to be the same as SFY2011.
August 25, 2011

Mr. Ross Edmunds
Idaho Department Health and Welfare
Division of Behavioral Health
P O Box 83720
Boise, ID 83720-0036

Dear Mr. Edmunds:

The Idaho Department of Juvenile Corrections (IDJC) is supportive of the 2012-2103 Combined Mental Health and Substance Abuse Block Grant. As you have described, the Block Grant goals of promoting improved services and implementing Evidence-Based Practices, for youth with emotional and behavioral disturbances, substance abuse issues, and/or co-occurring disorders are in line with our Department goals.

To date, there have been several successful collaborative efforts between the Division of Behavioral Health (DBH) and IDJC. The Department of Health and Welfare (H&W) has Memorandum of Agreements with IDJC and all of the county administered juvenile detention facilities in the state for placement of clinicians in the facilities. These detention clinicians assist with services for mental health issues. The state of Idaho uses some Children’s Mental Health program general funds to support the cost of these clinicians. Another effort with DBH includes the Juvenile Justice Children’s Mental Health (JJC MH) meetings. The JJC MH, which includes members from state, county, court, and consumer stakeholders, meets quarterly to resolve obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored dissemination on the implementation of a Youth Mental Health Court, which uses the wraparound service model, in three counties with interest in expansion to other counties. Another collaborative effort includes the Strengthening Families Round Table, which is a diverse group of stakeholders, who meet every other month to brainstorm innovative ideas for family empowerment and support. IDJC and DBH are finalizing a Memorandum of Understanding along with the courts for coordination of substance abuse services, as well as each partner’s roles and responsibilities for their shared populations in their respective programs.

The Department of Juvenile Corrections hopes to continue to collaborate with the Division of Behavioral Health. IDJC looks forward to future partnering opportunities toward achieving the Block Grant goals including collaborating with the courts to help youth and families navigate the continuum of care system, prevent or divert incarcerations, and facilitate smooth transitions back into the community.

Sincerely,

Sharon Harrigfeld
Director
August 18, 2011

Ross Edmunds
Idaho Department Health and Welfare
Division of Behavioral Health
P O Box 83720
Boise, ID 83702

Dear Mr. Edmunds:

The Idaho Division of Public Health, Bureau of Community and Environmental Health supports the 2012-2103 Combined Mental Health and Substance Abuse Block Grant. The Block Grant goals to promote improved services and implement evidence-based practices for youth with emotional and behavioral disturbances, adults with serious mental impairments, substance abuse issues, and/or co-occurring disorders, as well as to improve linkages between primary health and behavioral health are in line with the goals of the Division of Public Health (DOPH) and the Bureau of Community and Environmental Health.

To date, there has been successful collaboration between DOPH and the Division of Behavioral Health (DBH) on various efforts. Eligible children and families may access medical and preventative health services through the Idaho Department of Health and Welfare’s seven regional offices, Idaho’s seven local public health districts (through contracts with DOPH), as well as other organizations and providers. Local public health services may include community and home health nursing (family planning, immunizations, school-based nursing), WIC (supplemental nutrition program for women, infants and children) and school-based oral health services (education, fluoride treatments, and sealants). In addition, the Bureau of Community and Environmental Health’s past collaborative efforts with DBH include the SFY 2010 H1N1 Response Workgroup and the Substance Prevention and Treatment Tobacco Project. DBH and DOPH actively collaborate in the Idaho Suicide Prevention Council and the recent development of the Idaho Suicide Prevention Plan. This relationship fostered a collaborative roundtable effort lead by the Department of Education, to convene schools, law enforcement, and regional DBH staff to address suicide prevention, intervention, and postvention in schools. This collaboration also supplied schools with suicide prevention toolkits.

There are several future collaborative efforts between the Bureau of Community and Environmental Health and DBH including addressing and reducing chronic disease (chronic disease self-management programs and categorical chronic disease programs), adolescent pregnancy prevention, sexual violence prevention, physical activity and nutrition programs and tobacco prevention and control. The Bureau welcomes additional future collaborative opportunities and linkages that encourage primary and behavioral health care for Idaho citizens to address the whole person.

Sincerely,

[Signature]

ELKE SHAW-TULLOCH, MHS, Chief
Bureau of Community and Environmental Health
Division of Public Health
August 26, 2011

Idaho Department of Health and Welfare
Division of Behavioral Health
P O Box 83720
Boise, ID 83702

Dear Mr. Edmunds,

As the Idaho Department of Corrections (IDOC), we are supportive of the 2012-2103 Combined Mental Health and Substance Abuse Block Grant. As you have described, the Block Grant goals of promoting improved services and implementing Evidence-Based Practices, for adults with SMI and SMPI, substance abuse issues, and/or co-occurring disorders are in line with our Department goals.

Successful collaborative efforts between the Department of Corrections and the Division of Behavioral Health (DBH) already include service to individuals referred through Mental Health and Drug courts. Mental Health Courts frequently refer individuals to DBH for treatment. The model used to support Mental Health court referrals are ACT teams that work with court representatives to develop individualized treatment plans for court clients. The treatment plans help participants stabilize, learn life management skills, and avoid additional criminal activities. ACT staff attend weekly court sponsored meetings to discuss progress and needs of Mental Health Court referred clients. IDOC and DBH are finalizing a Memorandum of Understanding along with the courts for coordination of substance abuse services, as well as each partner's roles and responsibilities for their shared populations in their respective programs. A new law in 2011 allows Drug and Mental Health courts the option, if a defendant was placed on probation, to reduce a felony conviction to a misdemeanor, only upon a finding that such action was compatible with the public interest. Providing a chance for such defendants to have their convictions set aside could give them an added incentive to abide by the terms of probation and live law-abiding lives, and
would increase their employment and educational opportunities. This could allow further opportunity for IDOC and DBH to collaborate to help these court individuals. The Department of Corrections hopes to continue these collaborative efforts with the Division of Behavioral Health, as well as future partnering opportunities toward achieving the Block Grant goals. These Departments will continue to collaborate with each other and the courts to help individuals navigate the system of care continuum, prevent or divert incarceration, and facilitate smooth transitions back into the community.

Sincerely,
Brent Reinke, Director
Idaho Department of Corrections

Sincerely

Brent Reinke
Director

BDR/yj
August 26, 2011

Idaho Department Health and Welfare
Division of Behavioral Health
P O Box 83720
Boise, ID 83702

Dear Mr. Edmunds,

The Division of Family and Children's Services (FACS) is supportive of Idaho's 2012-2103 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant application. The Block Grant goals to improve services and implement Evidence-Based Practices for youth with emotional and behavioral disturbances, substance abuse issues, and/or co-occurring disorders are in line with our Division goals.

The Division of Family and Community Services has a history of collaborating with the Division of Behavioral Health (DBH) in an effort to provide best practice services to Idaho citizens. The Idaho FACS programs address child welfare and protection, foster care and adoption. The DBH Children's Mental Health programs work with local child welfare agencies to problem solve family issues that may put children at risk for maltreatment, out-of-home placement and involvement with the foster care system. A designated DBH program specialist serves as a liaison consultant to Child Welfare staff on issues related to mental health services access for children served through the child protection and adoption programs. Staff from both Divisions have been trained on the Treatment Foster Care model and they work together to implement the Treatment Foster Care training program. Representatives from DBH participated in the development of the Child and Family Services Review's (CFSR) Program Improvement Plan (PIP) and in on-site CFSR reviews. A Memorandum of Understanding (MOU) between the DBH and FACS (April 2011) outlines shared efforts regarding infant and early childhood mental health services. Another MOU describes the service coordination process for children served in both programs. The Department's Service Integration program works with Idaho's Health Information and Referral Center to facilitate family efforts to navigate the range of Department programs and services. The Substance Use Disorders (SUD) program has established Child Protection Drug Courts in Idaho.

FACS hopes to continue its collaborative efforts with DBH. FACS plans to explore future partnering opportunities with DBH in support of the Block Grant goals to help youth and families navigate the continuum of care system, prevent out-of-home placements, and facilitate smooth transitions back into the community.

Sincerely,

Robert B. Luce, Division Administrator
Division of Family and Children's Services

RBL/db
August 30, 2011

Idaho Department of Health and Welfare
Division of Behavioral Health
P O Box 83720
Boise, ID 83702

Dear Mr. Edmunds,

The intent of this letter is to express support for the 2012-2103 Combined Mental Health and Substance Abuse Block Grant. As you have described, the Block Grant goals of promoting improved services and implementing Evidence-Based Practices, for youth with emotional and behavioral disturbances, substance abuse issues, and/or co-occurring disorders are in line with our Department goals.

Successful collaborative efforts between the Department Education and the Division of Behavioral Health (DBH) currently include examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe and supported in their social-emotional development. For those youth at-risk of emotional, behavioral and substance use disorders, we partner to ensure they have the services and supports needed to succeed in academically, and socially as well. The Division’s Children’s Mental Health (CMH) program and the Department of Education collaborate with local school districts to implement intensive community and school-based programs for children and youth with serious emotional disorders (SED). The Division of Behavioral Health participates as a voting member of the Special Education Advisory panel, a federally funded group within each state that provides feedback to the Department of Education on issues that impact special education consumers, during their quarterly meetings. The Department of Health and Welfare provides technical assistance and professional subject matter expertise on youth with serious emotional and/or social disorders. One of the focus areas described in the report entitled “Idaho Substance Use Disorder Prevention and Treatment System: A Collaborative Strategy for 2008-2012” is collaboration with the Department of Education to implement core best practice and outcome measures for substance abuse prevention services in grades K-12.

The Department of Education hopes to continue these collaborative efforts with the Division of Behavioral Health, as well as future partnering opportunities toward achieving the Block Grant goals. These Departments will continue to collaborate with each other to help children, youth, and families navigate the system of care continuum, reduce out of home placements, and improve educational outcomes.

Respectfully,

Matt McCarter, Coordinator
Safe & Drug-Free Schools
21st CCLC
State Department of Education
(208)332-6960 mamccarter@sde.idaho.gov
August 29, 2011

Barbara Orlando
Office of Program Services, Division of Grant Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

RE: State of Idaho Application for 2011 Federal Community Mental Health Block Grant

Dear Ms. Orlando:

The Idaho State Planning Council on Mental Health (Council) reviewed, discussed and provided further comment to the Federal Block Grant at our annual meeting August 23-25, 2011.

The Federal Block Grant plays a key role in the provision of mental health services in Idaho especially in times of fiscally restrained budgets. The Idaho State Planning Council has diligently monitored the legislature as they struggle with decisions impacting our most vulnerable populations. The Council has been attentive in monitoring budget reductions and reorganization of services for children, youth, families, and individuals. We believe our role as Council members is more important then ever as we continue to inform and educate our elected officials.

Providing appropriate mental health services to individuals in Idaho is a perennial challenge for our State and we offer the following information related to Idaho’s Mental Health system of care.

- The Council participated in sharing information with the Department of Health and Welfare on housing issues and concerns regarding the direction of Idaho’s Shelter Care Plus program. The Council believes housing is a key component to successful treatment and will continue to support the need for creating future housing opportunities in Idaho.

- Informing our Legislature on the continued need to have available quality mental health services is of great importance to the Council. The Council presented testimony to the Joint Finance-Appropriation Committee on the concerns of current and future budget cuts to services and the impact those cuts impose on individuals receiving services.
• The Council encouraged and appreciated the efforts of the Governor’s Mental Health Transformation Workgroup in blending Mental Health and Substance Abuse in the overall system of care for Idaho citizens. The Council currently has a representative that participated on the Idaho Behavioral Health Interagency Cooperative. This is the next phase for transforming Idaho’s behavioral health system of care. This representative keeps the Council and the Regional Boards apprised of the process. We embrace their goals to increase availability of quality services and to create localized service delivery systems with local input from consumers and stakeholders.

• Hosting the annual legislative event and award ceremony expands our opportunity to inform and educate the public and our elected officials. The 2011 Legislative event was titled “Recovery.” The general focus of the event was to put a face on the many challenges that individuals have in navigating the mental health system. The panel provided information on their personal journey to success which illustrates that recovery is achievable in a variety of degrees. Awards were presented to recipients from the media, the judiciary, legislators, law enforcement, and community advocates for their exemplary work.

The Idaho State Planning Council on Mental Health is comprised of a dedicated group of champions providing a voice for many of our citizens. Our goal is to keep the Governor and State Legislature acutely aware of the need for providing quality mental health services to our citizens. We are committed to improving services for all individuals affected by mental illness.

Sincerely,

Teresa Wolf, Chair
Idaho State Planning Council on Mental Health
Executive Summary SFY 2012 (7/1/11-6/30/12) and SFY 2013 (7/1/12-6/30/13)  
State of Idaho Combined MHBG/SAPT Block Grant Application

The Department of Health and Welfare is designated by statute (Idaho Code Section 39 Chapter 3) as the State Mental Health Authority (SMHA) and as the Single State Authority (SSA) for Substance Use Disorders (SUD) prevention and treatment. Most of these responsibilities are carried out by the Department’s Division of Behavioral Health. The Division of Behavioral Health’s Central Office includes Adult Mental Health (AMH), Children’s Mental Health (CMH), Substance Use Disorders (SUD) and a data unit. The Central Office component of the Division of Behavioral Health provides system coordination and leadership, policy and standards development, rule promulgation and interpretation, technical assistance, training, consultation, funding application and regulation, and quality assurance monitoring. A total of seven (7) regions are organized into three service areas or “hubs,” with the DBH management team composed of the hub heads and the unit leads. Idaho’s two (2) state psychiatric hospitals, State Hospital North and State Hospital South, are also under the jurisdiction of the DBH Administrator. The SSA oversees treatment to adolescents, adults, pregnant women and women with dependent children who are below 200% of the federal poverty rate and who are diagnosed as substance dependent with at least an outpatient need according to the ASAM (PPC 2R, Level 1). The Division contracts with a management services contractor, Business Psychology Associates (BPA), to manage treatment service delivery through a network of Department approved treatment providers and to provide care management utilization review. The Division contracts with Benchmark Research and Safety (BRS), the Prevention Technical Assistance and Support Contractor (PTASC), to manage the community-based prevention provider network, to conduct annual state and regional needs assessments used to identify at-risk populations and underserved areas, and to support the preventionidaho.net provider data collection website.

The Governor appointed Behavioral Health Transformation Workgroup’s report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho’s Behavioral Health System (10/28/10) recommendations included 1) replacing regional mental health and substance use advisory boards and councils with Regional Behavioral Health Community Development Boards and a State Behavioral Health Council and 2) adopting the BHTWG’s proposed Array of Core Services. Governor Otter’s Executive Order 2011-01 (1/27/11) established the Idaho Behavioral Health Interagency Cooperative (IBHIC), with representation from the Department of Health and Welfare, Office of Drug Policy, Department of Correction, Department of Juvenile Corrections, State Mental Health Planning Council, Administrator of Idaho Courts, Superintendent of Public Instruction and counties. Idaho’s SFY 2012-2013 Combined Behavioral Health Assessment is built around the IBHIC transformation plan for behavioral health services. Priority areas include Adult Mental Health, Children’s Mental Health, Substance Abuse Prevention, Substance Abuse Treatment, Behavioral Health System Issues and Data and Quality Assurance.